Alaska Medicaid Program

ALASKA ELECTRONIC HEALTH RECORDS Incentive Program

Updated

November 2018

Provider Manual

Contents

1 Background

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs who adopt, implement, upgrade, or meaningfully use certified Electronic Health Records (EHR) technology. Under ARRA, states are responsible for identifying professionals and hospitals that are eligible for these Medicaid EHR incentive payments, making payments, and monitoring use of the payments. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt and meaningfully use certified EHR technology.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at https://www.healthit.gov/

Goals for the national program include:

- Enhance care coordination and patient safety;
- Reduce paperwork and improve efficiencies;
- Facilitate electronic information sharing across providers, payers, and state lines; and
- Enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of health care nationwide.

Resources:

- 7 AAC 165 - Alaska Medicaid Electronic Health Records Incentive Program Link
- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
- Alaska State Medicaid HIT Plan (SMHP)
- CMS information on the Promoting Interoperability (EHR) Program
- Office of the National Coordinator for Health Information Technology

List of Acronyms

AAC = Alaska Administrative Code
ARRA: American Recovery and Reinvestment Act of 2009
AIU = Adopt, Implement, Upgrade
CAH = Critical Access Hospital
CCN = Centers for Medicare & Medicaid Services Certification Number
CEHRT = Certified Electronic Health Record Technology
CFR = Code of Federal Regulations
CHIP = Children's Health Insurance Program
CMS = Centers for Medicare and Medicaid Services
CPOE = Computerized Physician Order Entry
CQM = Clinical Quality Measure
CY = Calendar Year
EHR = Electronic Health Record
EH = Eligible Hospital
EP = Eligible Professional
FFY = Federal Fiscal Year
FQHC = Federal Qualified Health Center
FY = Fiscal Year
HIE = Health Information Exchange
HIT = Health Information Technology
IHS = Indian Health Services
IT = Information Technology
MMIS = Medicaid Management Information System
NAAC = Net Average Allowable Cost
NHIN = National Health Information Network
NLR = National Level Registry
NPI = National Provider Identifier
ONC = Office of the National Coordinator for Health Information Technology
PECOS = Provider Enrollment, Chain and Ownership System
POS = Place of Services
PQRI = Physician Quality Reporting Initiative
RHC = Rural Health Clinic
SLR = State Level Registry
SMHP = State Medicaid Health Information Technology Plan
SSN = Social Security Number
TIN = Tax Identifier Number

2 How Do I use this manual?

The Alaska Electronic Health Records Incentive Program Provider Manual is a resource for healthcare professionals and hospitals who wish to learn more about the Alaska Medicaid EHR Incentive Program including detailed information and resources on eligibility and attestation criteria. This manual provides details on how to apply for program incentive payments via the Alaska Medicaid State Level Registry (SLR), which is the Department's web-based EHR Incentive Program attestation system.

The best way for a new user to orient themselves to the EHR Incentive Program requirements and processes is to read through each section of this manual in its entirety prior to starting the application process.

This manual is organized by EHR Incentive program eligibility requirements, patient volume methodology, program payment methodology, meaningful use quality measures and program registration requirements for both EPs and EHs, information on Stage 1, Modified Stage 2 and Stage 3 Meaningful Use, along with the SLR application process.

3 How do I get help?

If you have any questions or problems, please contact the Health Information Technology, EHR Incentive Program Office. EHR Incentive Program Office is the central point-of-contact to aid providers in enrolling in the Alaska Medicaid EHR Incentive Program and providing education and outreach to all Alaska Medical Assistance enrolled providers.

Address: 3601 C Street, Suite 902, Anchorage, AK 99503

Email Address: hss.hitinfo@alaska.gov

There are a number of resources available to assist providers with the Alaska Medicaid EHR Incentive Program application process. These resources can be found on our Provider Outreach Page at: http://ak.arraincentive.com/.

4 Eligible provider types

Per the federal rule, EPs and EHs must begin participation in the program no later than calendar year (CY) 2016. The following Alaska Medical Assistance providers and out-of-state providers who are enrolled in the Alaska Medicaid Program are eligible to participate in the Alaska Medicaid EHR Incentive Program.

Eligible professionals

- physician (MD and DO)
- dentist
- certified nurse-midwife
- nurse practitioner
- physician assistant practicing in a Federally Qualified Health Center (FQHC) led by a physician assistant or a rural health clinic (RHC), that is so led by a physician assistant

For the purposes of the EHR Incentive Program a Tribal clinic is considered a FQHC. A physician assistant practicing in a Tribal clinic must meet the same requirements of a physician assistant practicing in a FQHC. Any other provider that practices in a Tribal clinic follows the same rules as a FQHC.

Physician Assistant (PA) led Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) means a PA is:

- The primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);
- A clinical or medical director at a clinical site of practice; or
- An owner of an RHC.

Eligible hospitals

Alaska paid our last incentive payment to Eligible Hospitals (EH) in Program Year 2017. There will be no Eligible Hospital for Program Year 2018 and beyond. *Information provided as a reference only.*

- Acute care hospitals, including critical access hospitals (CAHs)
- Children's hospitals

5 Enrollment requirements

Requirements for an eligible professional

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must meet the following criteria:

- Meet one of the following patient volume criteria:
  - Have a minimum of 30 percent patient volume attributable to services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (specific criteria apply)
  - Have a minimum 20 percent patient volume attributable to services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (specific criteria apply), and be a pediatrician*; or
  - Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals
- Have a valid contract with Alaska Medical Assistance**;
- Have no sanctions and/or exclusions;
- Hospital-based providers may be eligible if they purchase and use their own EHR program (hospital based is defined as 90% or more of services are performed in a hospital inpatient or emergency room setting)

* For the purposes of this program, the Department defines pediatricians as a practitioner who is board certified through the American Board of Pediatrics web site ***or*** through the American Osteopathic Board of Pediatrics.

** A valid contract means that the provider is currently enrolled with Alaska Medicaid Program to provide services. An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he/she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System. The TIN of the individual or entity receiving the incentive payment must match a TIN linked to the individual provider in the Medicaid Management Information System (MMIS). For entities that do not link providers to their MMIS enrollment, the provider must be in contractual arrangement with the group or clinic to which they assign their payment.

Providers and hospitals currently ineligible for the Alaska Medicaid EHR Incentive Program include behavioral health (substance abuse and mental health) providers and facilities and long-term care providers and facilities. Note that some provider types eligible for the Medicare program, such as chiropractors, are not eligible for the Alaska Medicaid EHR Incentive Program per federal regulations.

Requirements for an eligible hospital

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must meet the following criteria:

- An acute care hospital including Critical Access Hospitals (CAH)
    - Acute Care and Critical Access Hospitals must have:
        - Medicaid discharges of at least 10% for the Medicaid patient volume,
        - An average Length of Stay (LOS) of 25 days or less,
        - A CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment.
- A children's hospital
    - Children's Hospitals without a CCN, because they do not serve Medicare beneficiaries but have received alternate numbers from CMS for Incentive Program participation are eligible. They do not have to meet the patient volume threshold.

Qualifying providers by provider type and patient volume

Provider Types	Patient Volume over 90-days Period
Eligible Hospital	
Acute Care Hospital (includes Critical Assess Hospitals)	• 10% Medicaid related encounters
Children's Hospital	• No Medicaid volume requirement
Eligible Professional	
Physicians (M.D., D.O.)	• 30% Medicaid related encounters • For EP's practicing in a FQHC/RHC - 30% Needy Individuals
Dentists	
Certified Nurse Midwives	
Nurse Practitioners	
PA's when practicing at an FQHC/RHC that is led by a PA	
Pediatrician	• 30% Medicaid related encounters • If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

Out-of-state providers

The Alaska Medicaid EHR Incentive Program allows out-of-state provider to participate in this advantageous program. Out-of-state providers have the same eligibility requirements as in-state providers. Alaska must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Alaska Department of Health and Social Services or Centers for Medicare and Medicaid Services. Records must be maintained as applicable by law in the State of practice or Alaska, whichever is deemed longer. The out of state provider must be enrolled with Alaska Medicaid Program in order to participate in the Alaska Medicaid EHR Incentive Program.

6 Patient volume methodology

A Medicaid provider must annually meet patient volume requirements for the Alaska Medicaid EHR Incentive Program as established through the State's CMS approved SMHP.

Eligible professional patient encounter calculation

EP patient volume for those not practice predominantly in a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal clinic will be calculated based on Medicaid and out-of-state Medicaid patients. For EPs practicing predominantly in a FQHC or RHC the patient volume is calculated using the needy individual patient volume requirements. Practicing predominantly is defined as an EP practicing at an FQHC or a RHC clinical location for over 50 percent of his or her total patient encounters over a period of 6 months.

The EP Medicaid patient volume or needy individual patient volume is calculated based on unique patient encounters per day for the 90-day period in the previous calendar year or in the twelve months preceding the providers' attestation date.

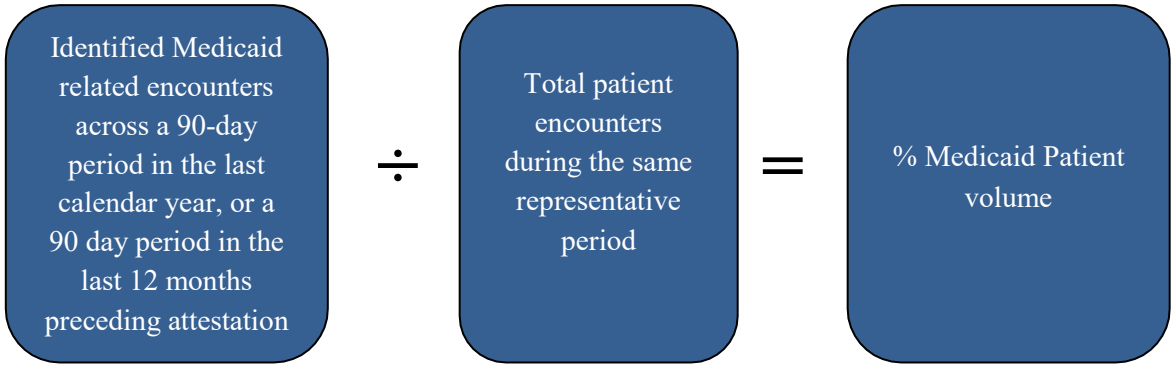
Eligible professional Medicaid encounter

For purposes of calculating the EP patient volume, a Medicaid encounter is defined as services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims and encounters. Zero-pay claims include:

- Claims denied because the Medicaid beneficiary has maxed out the service limit
- Claims denied because the service wasn't covered under the State's Medicaid Program
- Claim paid at $0 because another payer's payment exceeded the Medicaid payment
- Claim denied because the claim wasn't submitted timely.

To calculate Medicaid patient volume, an EP must divide:

- The total identified Medicaid or out of-state Medicaid related patient encounters
    a. in any representative 90-day period in the preceding calendar year, or
    b. in any 3 month period in the preceding year that is 90-days or greater, or
    c. the full preceding calendar year, or
    d. in any 90-day period in the last 12 months preceding the provider's attestation; by
- The total patient encounters in the same time period.



Eligible professional needy individual encounter

For purposes of calculating the patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- The identified Eligible Professional Medicaid Encounter definition listed on the prior page
- Furnished by the provider as uncompensated care, or **
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

**For providers practicing in a Tribal clinic, uncompensated care is a calculated figure, using charity care and bad debt to determine the number of encounters that are considered uncompensated care. Indian Health Services (IHS) has defined uncompensated care as:

Total Visits - Paid Visits (regardless of payer)* - Charity Care (special fund that people qualify for [this is 0 for Tribes/Urban]) – Bad Debt = Uncompensated Care.

*Under the paid visits figure IHS is not considered a payer.

To calculate needy individual patient volume, an EP must divide:

1. The total identified needy individual Medicaid or out of-state Medicaid related patient encounters
    a. in any representative 90-day period in the preceding calendar year, or
    b. in any 3 month period in the preceding year that is 90-days or greater, or
    c. the full preceding calendar year, or
    d. in any 90-day period in the last 12 months preceding the provider's attestation; by
2. The total patient encounters in the same time period.

Group practice patient encounter calculation

Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP;
- There is an auditable data source to support the clinic's or group practice's patient volume determination;
- All EPs in the group practice or clinic must use the same methodology for the payment year;
- The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EPs outside encounters.

Group encounters can be totaled in one of two different ways:

- The entire clinic/group practice Medicaid encounter total, or
- Only those providers in the group encounter total that are considered eligible professionals for the Medicaid Incentive Payment Program whether or not they are attesting for the program in that year.

The group patient volume for a non-Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal clinic will be calculated based on eligible Medicaid Encounters and out-of-state Medicaid patients. The group patient volume for a FQHC, RHC or Tribal clinic is calculated using the needy individual patient volume requirements if the providers within the group practiced predominantly in the FQHC, RHC or Tribal clinic in the previous calendar year.

Group Medicaid encounters

To calculate the group practice patient volume, a group must divide:

1. The group's total identified Medicaid or out of-state Medicaid related patient encounters
    a. in any representative 90-day period in the preceding calendar year, or
    b. in any 3 month period in the preceding year that is 90-days or greater, or
    c. the full preceding calendar year, or
    d. in any 90-day period in the last 12 months preceding the provider's attestation; by
2. The total patient encounters in the same time period.

For groups choosing to use "in any 90-day period in the last 12 months preceding the provider's attestation", there is a CMS FAQ that addresses the likelihood of the group attestations being completed on different days and then having different time periods. FAQ #9822 can be found at this website: CMS-Frequently Asked Questions (FAQs)

Group needy individual encounters

In order for providers to use the group needy individual patient volume, all providers within the group must have practiced predominantly in the FQHC, RHC or Tribal clinic for 50% of their encounters over a 6 month time period in the previous calendar year or in the 12 months preceding the attestation.

To calculate the group needy individual patient volume, a group must divide:

1. The group's total identified needy individual Medicaid or out of-state Medicaid related patient encounters
    a. in any representative 90-day period in the preceding calendar year, or
    b. in any 3 month period in the preceding year that is 90-days or greater, or
    c. the full preceding calendar year, or
    d. in any 90-day period in the last 12 months preceding the provider's attestation; by
2. The total patient encounters in the same 90-day or greater period.

Eligible hospital patient encounter calculation

For purposes of calculating EH patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims. Zero pay claims include:

- Claims denied because the Medicaid beneficiary has maxed out the service limit
- Claims denied because the service wasn't covered under the State's Medicaid Program
- Claim paid at $0 because another payer's payment exceeded the Medicaid payment
- Claim denied because the claim wasn't submitted timely.

In order for emergency room encounters to count towards the patient volume the emergency department must be part of the hospital.

Exception - A children's hospital is not required to meet Medicaid patient volume requirements.

To calculate Medicaid patient volume, an EH must divide:

1. The total identified Medicaid or out of-state Medicaid related patient encounters
    a. in any representative 90-day period in the preceding federal fiscal year, or
    b. in any 3 month period in the preceding federal fiscal year that is 90-days or greater, or
    c. the full preceding federal fiscal year, by
2. The total encounters in the same identified period.
    a. Total number of inpatient discharges for the selected period; the encounters also include discharges within the 90 days in which the patient was admitted prior to the start of the selected period plus could include the total number of emergency department visits in the same identified period.

7 Electronic health record functions

Please note: Program Year 2016 was the LAST year a provider can enroll in the Medicaid EHR Incentive Program

Adopt, Implement or Upgrade (AIU)

Federal regulations allow EPs and EHs who participate in the Alaska Medicaid EHR Incentive Program to receive incentive payments if they adopt, implement or upgrade to a certified EHR technology in the first year of participation. (This option is not available through the Medicare Incentive Program in which all providers must meet meaningful use in the first year.) At the time of attestation, the EP or EH will be required to provide documentation supporting the claim of AIU, such as a contract or paid invoice.

What does Adopt, Implement or Upgrade Mean?	
Adopt	Acquire, purchase, or secure access to certified EHR technology
Implement	Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements;
Upgrade	Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Meaningful Use (MU)

The Medicare and Medicaid EHR Incentive Programs provide financial incentives for the "meaningful use" of certified EHR technology to improve patient care. To receive an EHR incentive payment, providers have to show that they are "meaningfully using" their EHRs by meeting thresholds for a number of objectives. CMS has established the objectives for "meaningful use" that eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must meet in order to receive an incentive payment.

Adopt, Implement, Upgrade in Year 1

EPs that adopt, implement, or upgrade in their first year of participation do not have to report meaningful use during the first payment year. In the second year of participation, EPs must display meaningful use for a selected 90 day reporting period.

In Program Year 2018, all providers will once again be attesting to a minimum 90-day EHR Reporting Period for the Meaningful Use Objectives and Measures

Payment years do not have be consecutive until 2016.

EHR Incentive Payment Timelines

	1st Payment Received in 2011	1st Payment Received in 2012	1st Payment Received in 2013	1st Payment Received in 2014	1st Payment Received in 2015	1st Payment Received in 2016
2011 Payment amount	$21,250.00	$0.00	$0.00	$0.00	$0.00	$0.00
2012 Payment amount	$8,500.00	$21,250.00	$0.00	$0.00	$0.00	$0.00
2013 Payment amount	$8,500.00	$8,500.00	$21,250.00	$0.00	$0.00	$0.00
2014 Payment amount	$8,500.00	$8,500.00	$8,500.00	$21,250.00	$0.00	$0.00
2015 Payment amount	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$21,250.00	$0.00
2016 Payment amount	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$21,250.00
2017 Payment amount	$0.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00
2018 Payment amount	$0.00	$0.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00
2019 Payment amount	$0.00	$0.00	$0.00	$8,500.00	$8,500.00	$8,500.00
2020 Payment amount	$0.00	$0.00	$0.00	$0.00	$8,500.00	$8,500.00
2021 Payment amount	$0.00	$0.00	$0.00	$0.00	$0.00	$8,500.00
Total Payments	$63,750.00	$63,750.00	$63,750.00	$63,750.00	$63,750.00	$63,750.00

2018 Program Requirements

Eligible Hospitals and Eligible Professionals that attest directly to a state for the state's Medicaid EHR Incentive Program will continue to attest to the measures and objectives as finalized in the 2015 EHR Incentive Programs Final Rule (80 FR 62762 through 62955).

For **Program Year 2018**, you still have the option to report on Modified Stage 2 or Stage 3 Objectives. You are also able to use either a 2014 or 2015 Certified EHR System. **Starting in Program Year 2019,** you will be **required** to be using a 2015 Certified EHR System AND you can **only report** on Stage 3 Objectives.

To access the **2018 Modified Stage 2 program requirements** specific to eligible hospitals and EPs attesting to their state's Medicaid EHR Incentive Program, click here.

EHR Reporting Period

- In Program Year 2018, **all** providers will once again be attesting to a minimum 90-day EHR Reporting Period for the **Meaningful Use Objectives and Measures**.
- The CQM reporting period for Eligible Professionals who are attesting to Meaningful Use criteria for the **first time** is any continuous 90-day period between January 1, 2018 and December 31, 2018.
- The CQM reporting period for Eligible Professionals who have **successfully demonstrated any stage of Meaningful use in a prior year**, is the full calendar year from January 1, 2018 through December 31, 2018.

Objectives and Measures

- **View the 2018** Specification Sheets for Meaningful Use **Modified Stage 2** EPs and hospitals.
  - In 2018, all providers must attest to objectives and measures using EHR technology certified to the 2014 Edition. If it is available, providers may also attest using EHR technology certified to the 2015 Edition, or a combination of the two.
    - There are changes to the measure calculations policy, which specifies that actions included the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. Specific measures affected are identified in the Additional Information section of the specification sheets.

Requirements for Medicaid EHR Incentive Program in 2018 Resources

- Security Risk Analysis Tip Sheet
- Updated Security Risk Assessment Tool
- Guide for Eligible Professionals Practicing in Multiple Locations
- Patient Electronic Access Tip Sheet
- Medicaid Eligible Professionals: Public Health Reporting
- Medicaid Eligible Hospitals: Public Health Reporting

Objectives for 2018	Measures for Providers in 2018	Exclusions and/or Specifications for Certain Providers
Objective 1: Protect Patient Health Information	**Measure**: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct Identified security deficiencies as part of the EP's risk management process.	**NONE**
Objective 2: Clinical Decision Support	*In order for EPs to meet the objective they must satisfy both of the following measures:* **Measure 1**: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions. **Measure 2**: The EP has enabled and implemented the functionality for drug-drug and Drug-allergy interaction checks for the entire EHR reporting period.	**Exclusion:** For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.
Objective 3: Computerized Provider Order Entry	**Measure 1**: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Measure 2**: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Measure 3**: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	**Exclusions:** **Measure 1:** Any EP who writes fewer than 100 medication orders during the EHR reporting period. **Measure 2:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. **Measure 3:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

Objective 4: Electronic Prescribing (eRx)	**EP Measure**: More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	**Exclusions:** Writes fewer than 100 permissible prescriptions during the EHR reporting period; or Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.
Objective 5: Health Information Exchange	**Measure:** The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	**Exclusions:** Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.
Objective 6: Patient Specific Education	**EP Measure**: Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.	**Exclusion**: Any EP who has no office visits during the EHR reporting period
Objective 7: Medication Reconciliation	**Measure**: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	**Exclusion**: Any EP who was not the recipient of any transitions of care during the EHR reporting period.
Objective 8: Patient Electronic Access (VDT)	*EPs must satisfy both measures in order to meet this objective:* **Measure 1:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. **Measure 2:** For an EHR reporting period in 2017 and 2018 more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.	**Exclusion** **Measure 1:** Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information." **Measure 2:** Any EP who: Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or Conducts 50 percent or more of his or her patient encounters in a county that

		does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.
Objective 9: Secure Messaging	**Measure:** For an EHR reporting period in **2018**, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.	**Exclusion**: Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Objective 10: Public Health Reporting:	*EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.* **Measure Option 1 – Immunization Registry Reporting**: The EP is in active engagement with a public health agency to submit immunization data. **Measure Option 2 – Syndromic Surveillance Reporting**: The EP is in active engagement with a public health agency to submit syndromic surveillance data. **Measure Option 3 – Specialized Registry Reporting:** The EP is in active engagement to submit data to a specialized registry.	**Exclusions:** **Measure 1**: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP— Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period; Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period. **Measure 2*:*** Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP— Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; -Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or -Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. **Measure 3:** Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP— -Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;

Objectives for 2018	Measures for Hospitals/CAH in 2018	Exclusions and/or Specifications for Certain Hospitals/CAH
Objective 1: Protect Patient Health Information	**Measure:** Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the eligible hospital or CAH's risk management process.	**NONE**
Objective 2: Clinical Decision Support	**Measure 1**: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. **Measure 2**: The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.	***NONE***
Objective 3: Computerized Provider Order Entry	**Measure 1**: More than 60 percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. **Measure 2:** More than 30 percent of laboratory orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. **Measure 3**: More than 30 percent of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.	***NONE***

Objective 4: Electronic Prescribing	**Eligible Hospital/CAH Measure**: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.	**Exclusion**: Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that accepts electronic prescriptions at the start of their EHR reporting period.
Objective 5: Health Information Exchange	**Measure:** The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	**NONE**
Objective 6: Patient Specific Education	**Measure:** More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient specific education resources identified by CEHRT.	**NONE**
Objective 7: Medication Reconciliation	**Measure**: The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	**NONE**
Objective 8: Patient Electronic Access (VDT)	**Measure 1**: More than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information. **Measure 2:** For an EHR reporting period in 2017, more than 5 percent of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) view, download or transmit to a third party their health information during the EHR reporting period	**Exclusion** **Measure 2:** Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

Objective 9: Public Health Reporting	**Measure Option 1 – Immunization Registry Reporting**: The eligible hospital or CAH is in active engagement with a public health agency to submit immunization data. **Measure Option 2 – Syndromic Surveillance Reporting:** The eligible hospital or CAH is in active engagement with a public health agency to submit syndromic surveillance data. **Measure Option 3 – Specialized Registry Reporting:** The eligible hospital or CAH is in active engagement to submit data to a specialized registry. **Measure Option 4 – Electronic Reportable Laboratory Result Reporting:** The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory (ELR) results.	**Exclusions:** **Measure 1**: Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the eligible hospital or CAH— Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period; Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the eligible hospital or CAH at the start of the EHR reporting period. **Measure 2:** Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the eligible hospital or CAH— Does not have an emergency or urgent care department; Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from eligible hospitals or CAHs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from eligible hospitals or CAHs at the start of the EHR reporting period. **Measure 3:** Any eligible hospital or CAH meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the eligible hospital or

		CAH— Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period; Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or Operates in a jurisdiction where no specialized registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period. **Measure 4:** Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the electronic reportable laboratory result reporting measure if the eligible hospital or CAH— Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period; Operates in a jurisdiction for which no public health agency is capable of accepting the specific ELR standards required to meet the CEHRT definition at the start of the EHR reporting period; or Operates in a jurisdiction where no public health agency has declared readiness to receive electronic reportable laboratory results from eligible hospitals or CAHs at the start of the EHR reporting period.

Meaningful Use Clinical Quality Measures (CQMs) for both EPs and EHs

CQMs - Reporting Requirements from 2017 through 2018

2018 - EP's are required to report only **6** CQMs relevant to the scope of practice; reduced from current requirement of reporting 9 CQMs.

- The final rule aligns Medicaid EP CQMs to MIPS reducing the set of available CQMs from 64 to **53**
- CQM reporting period is a full year

2018 - EH's CQM reporting policies:

- Reducing the number of *eCQMs* submitted from 8 to **4**
- Reducing data submission to one calendar quarter
- CMS is not making any changes to policies for reporting CQMs by attestation
- Required number of CQMs reported via *attestation* remains at **16**
- CQM reporting period remains at a full year for returning EHs
- CQM reporting period for first-time Meaningful Use (MU) remains at any continuous **90**-days

There is not a required core of CQM's. Instead, CMS has identified two recommended core sets of CQM's – one for adults and one for children – that focus on high-priority health conditions and best practices for care delivery. Below are the links for the two core sets:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_CQM_PrediatricRecommended_CoreSetTable.pdf
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_CQM_AdultRecommend_CoreSetTable.pdf

CMS eMeasure ID	NQF	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS146v2	0002	Appropriate Testing for Children with Pharyngitis	Percentage of children 2- 18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis	Children age 2-18 years who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement	National Committee for Quality Assurance	Efficient Use of Healthcare Resources

					period and an antibiotic ordered on or three days after the visit		
CMS137v2	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Numerator 1: Patients who initiated treatment within 14 days of the diagnosis Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS165v2	0018	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the	National Committee for Quality Assurance	Clinical Process/ Effectiveness

			measurement period.	measurement period.	measurement period		
CMS156v2	0022	Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	Numerator 1: Patients with an order for at least one high-risk medication during the measurement period. Numerator 2: Patients with an order for at least two different high-risk medications during the measurement period.	Patients 66 years and older who had a visit during the measurement period	National Committee for Quality Assurance	Patient Safety
CMS155v2	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/ Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for	Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period Numerator 2: Patients who had counseling for nutrition during the measurement period Numerator 3: Patients who had counseling for physical activity during the measurement period	Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/ gynecologist (OB/GYN) during the measurement period	National Committee for Quality Assurance	Population/ Public Health

			nutrition - Percentage of patients with counseling for physical activity				
CMS138v2	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user	All patients aged 18 years and older	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Population/ Public Health
CMS125v2	0031	Breast Cancer Screening	Percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.	Women with one or more mammograms during the measurement period or the year prior to the measurement period	Women 41–69 years of age with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS124v2	0032	Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	Women with one or more Pap tests during the measurement period or the two years prior to the measurement period	Women 23-64 years of age with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS153v2	0033	Chlamydia Screening for Women	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one	Women with at least one chlamydia test during the measurement period	Women 16 to 24 years of age who are sexually active and who had a visit in the measurement	National Committee for Quality Assurance	Population/ Public Health

			test for chlamydia during the measurement period.		period		
CMS130v2	0034	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below: - Fecal occult blood test (FOBT) during the measurement period - Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period - Colonoscopy during the measurement period or the nine years prior to the measurement period	Patients 50-75 years of age with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS126v2	0036	Use of Appropriate Medications for Asthma	Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	Patients who were dispensed at least one prescription for a preferred therapy during the measurement period	Patients 5-64 years of age with persistent asthma and a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness

CMS117v2	0038	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday	Children who turn 2 years of age during the measurement period and who have a visit during the measurement period	National Committee for Quality Assurance	Population/ Public Health
CMS147v2	0041	Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization	All patients aged 6 months and older and seen for a visit between October 1 and March 31	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Population/ Public Health
CMS127v2	0043	Pneumonia Vaccination	Percentage of patients 65 years of age and	Patients who have ever received a	Patients 65 years of age and older with a	National Committee for	Clinical Process/

		Status for Older Adults	older who have ever received a pneumococcal vaccine.	pneumococcal vaccination	visit during the measurement period	Quality Assurance	Effectiveness
CMS166v3	0052	Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Patients without an imaging study conducted on the date of the outpatient or emergency department visit or in the 28 days following the outpatient or emergency department visit	Patients 18-50 years of age with a diagnosis of low back pain during an outpatient or emergency department visit	National Committee for Quality Assurance	Efficient Use of Healthcare Resources
CMS131v2	0055	Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS123v2	0056	Diabetes: Foot Exam	Percentage of patients aged 18-75 years of age with diabetes who	Patients who received visual, pulse and sensory foot	Patients 18-75 years of age with diabetes with a visit during	National Committee for Quality	Clinical Process/ Effectiveness

			had a foot exam during the measurement period.	examinations during the measurement period	the measurement period	Assurance	
CMS122v2	0059	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS148v2	0060	Hemoglobin A1c Test for Pediatric Patients	Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period	Patients with documentation of date and result for a HbA1c test during the measurement period	Patients 5 to 17 years of age with a diagnosis of diabetes and a face-to-face visit between the physician and the patient that predates the most recent visit by at least 12 months	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS134v2	0062	Diabetes: Urine Protein Screening	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	Patients with a screening for nephropathy or evidence of nephropathy during the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS163v2	0064	Diabetes: Low Density Lipoprotein (LDL)	Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately	Patients whose most recent LDL-C level performed during the measurement period is	Patients 18-75 years of age with diabetes with a visit during the measurement	National Committee for Quality Assurance	Clinical Process/ Effectiveness

		Management	controlled (<100 mg/dL) during the measurement period.	<100 mg/dL	period		
CMS164v2	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.	Patients who have documentation of use of aspirin or another antithrombotic during the measurement period	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS154v2	0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not	Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory	Children age 3 months to 18 years who had an outpatient or emergency department (ED)	National Committee for Quality Assurance	Efficient Use of Healthcare Resources

			dispensed an antibiotic prescription on or three days after the episode.	infection	visit with a diagnosis of upper respiratory infection (URI) during the measurement period		
CMS145v2	0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy	Patients who were prescribed beta-blocker therapy	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF <40%	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS182v3	0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular	Numerator 1: Patients with a complete lipid profile performed during the measurement period Numerator 2: Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period, or who were discharged alive for acute myocardial infarction (AMI), coronary artery	National Committee Quality Assurance	Clinical Process/ Effectiveness

			disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).		bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period		
CMS135v2	0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge	Patients who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS144v2	0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed	Patients who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%	American Medical Association-convened Physician Consortium for Performance Improvement	Clinical Process/ Effectiveness

		(LVSD)	beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge			® (AMA-PCPI)	
CMS143v2	0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months	Patients who have an optic nerve head evaluation during one or more office visits within 12 months	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS167v2	0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months	Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months	All patients aged 18 years and older with a diagnosis of diabetic retinopathy	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness

CMS142v2	0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months	Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care	All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS139v2	0101	Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	Patients who were screened for future fall risk at least once within the measurement period	Patients aged 65 years and older with a visit during the measurement period	National Committee for Quality Assurance	Patient Safety
CMS161v2	0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-	Clinical Process/ Effectiveness

			episode was identified			PCPI)	
CMS128v2	0105	Anti-depressant Medication Management	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	Numerator 1: Patients who have received antidepressant medication for at least 84 days (12 weeks) of continuous treatment during the 114-day period following the Index Prescription Start Date Numerator 2: Patients who have received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day period following the Index Prescription Start Date	Patients 18 years of age and older with a diagnosis of major depression in the 270 days (9 months) prior to the measurement period or the first 90 days (3 months) of the measurement period, who were treated with antidepressant medication, and with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS136v3	0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication	Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with	Numerator 1: Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSD Numerator 2: Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation	Initial Patient Population 1: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period Initial Patient Population 2: Children 6-12 years	National Committee for Quality Assurance	Clinical Process/ Effectiveness

			prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Phase, and at least two follow-up visits during the Continuation and Maintenance Phase. One of the two visits during the Continuation and Maintenance Phase may be a telephone visit with a practitioner.	of age who were dispensed an ADHD medication during the Intake Period and who remained on the medication for at least 210 days out of the 300 days following the IPSD, and who had a visit during the measurement period.		
CMS169v2	0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Patients in the denominator with evidence of an assessment for alcohol or other substance use following or concurrent with the new diagnosis, and prior to or concurrent with the initiation of treatment for that diagnosis. (Note: the endorsed measure calls for the assessment to be performed prior to discussion of the treatment plan with the	Patients 18 years of age or older at the start of the measurement period with a new diagnosis of unipolar depression or bipolar disorder during the first 323 days of the measurement period, and evidence of treatment for unipolar depression or bipolar disorder within 42 days of diagnosis. The	Center for Quality Assessment & Improvement in Mental Health (CQAIMH)	Clinical Process/ Effectiveness

				patient, but the current approach was considered more feasible in an EHR setting. The "Assessment for Alcohol or Other Drug Use" required in the numerator is meant to capture a provider's assessment of the patient's symptoms of substance use. The essence of the measure is to avoid treating the patient for unipolar depression or bipolar disorder without an assessment of their use of alcohol or other drugs.)	existence of a 'new diagnosis' is established by the absence of diagnoses and treatments of unipolar depression or bipolar disorder during the 180 days prior to the diagnosis.		
CMS157v2	0384	Oncology: Medical and Radiation – Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Patient visits in which pain intensity is quantified	All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Patient and Family Engagement

CMS141v3	0385	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	Patients who are referred for chemotherapy, prescribed chemotherapy, or who have previously received adjuvant chemotherapy within the 12 month reporting period	All patients aged 18 through 80 years with colon cancer with AJCC Stage III colon cancer	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS140v2	0387	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	All female patients aged 18 years and older with a diagnosis of breast cancer with stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS129v3	0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR	Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer	Equals Initial Patient Population at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam	American Medical Association-convened Physician Consortium for Performance	Efficient Use of Healthcare Resources

		Cancer Patients	external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer		radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy	Improvement ® (AMA-PCPI)	
CMS62v2	0403	HIV/AIDS: Medical Visit	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit	Patients with at least two medical visits during the measurement year with a minimum of 90 days between each visit	All patients, regardless of age, with a diagnosis of HIV/AIDS seen within a 12 month period	National Committee for Quality Assurance (NCQA)	Clinical Process/ Effectiveness
CMS52v2	0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	Numerator 1: Patients who were prescribed pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm3 Numerator 2: Patients who were prescribed pneumocystic jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/ mm3 or a CD4 percentage below 15%	Denominator 1: All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3 who had at least two visits during the measurement year, with at least 90 days in between each visit Denominator 2: All patients aged 1-5 years of age with a	National Committee for Quality Assurance (NCQA)	Clinical Process/ Effectiveness

				Numerator 3: Patients who were prescribed Pneumocystic jiroveci pneumonia (PCP) prophylaxis at the time of diagnosis of HIV	diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15% who had at least two visits during the measurement year, with at least 90 days in between each visit Denominator 3: All patients aged 6 weeks to 12 months with a diagnosis of HIV who had at least two visits during the measurement year, with at least 90 days in between each visit		
CMS77v2	TBD	HIV/AIDS: RNA Control for Patients with HIV	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.	Patients whose most recent HIV RNA level is <200 copies/mL.	All patients aged 13 years and older with a diagnosis of HIV/AIDS with at least two visits during the measurement year, with at least 90 days between each visit.	Centers for Medicare & Medicaid Services (CMS)	Clinical Process/ Effectiveness

CMS2v3	0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Population/ Public Health
CMS68v3	0419	Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name,	Eligible professional attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and	All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Patient Safety

			dosage, frequency and route of administration.	route of administration			
CMS69v2	0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 Age 18-64 years BMI ≥ 18.5 and < 25	Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters.	There are two (2) Initial Patient Populations for this measure NOTE: The most recent quality code submitted will be used for performance calculation. Initial Patient Population 1: All patients 65 years of age and older before the beginning of the measurement period with at least one eligible encounter during the measurement period NOT INCLUDING encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Population/ Public Health

					would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate. Initial Patient Population 2: All patients 18 through 64 years before the beginning of the measurement period with at least one eligible encounter during the measurement period NOT INCLUDING encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is		

					any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate		
CMS132v2	0564	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence	Patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence	All patients aged 18 years and older who had cataract surgery and no significant ocular conditions impacting the surgical complication rate	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Patient Safety
CMS133v2	0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated	Patients who had best-corrected visual acuity of 20/40 or better (distance or near)	All patients aged 18 years and older who had cataract surgery	American Medical Association-convened	Clinical Process/

		Following Cataract Surgery	cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery	achieved within 90 days following cataract surgery		Physician Consortium for Performance Improvement ® (AMA-PCPI)	
CMS158v2	0608	Pregnant women that had HBsAg testing	This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	Patients who were tested for Hepatitis B surface antigen (HBsAg) during pregnancy within 280 days prior to delivery.	All female patients aged 12 and older who had a live birth or delivery during the measurement period.	OptumInsight	Clinical Process/ Effectiveness
CMS159v2	0710	Depression Remission at Twelve Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9	Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter.	MN Community Measurement	Clinical Process/ Effectiveness

			score indicates a need for treatment				
CMS160v2	0712	Depression Utilization of the PHQ-9 Tool	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit.	Adult patients who have a PHQ-9 tool administered at least once during the four-month period.	Adult patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during each four month period	MN Community Measurement	Clinical Process/ Effectiveness
CMS75v2	TBD	Children Who Have Dental Decay or Cavities	Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.	Children who had cavities or decayed teeth.	Children, age 0-20 years, with a visit during the measurement period.	Centers for Medicare & Medicaid Services (CMS)	Clinical Process/ Effectiveness
CMS177v2	1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Patient visits with an assessment for suicide risk	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Patient Safety
CMS82v1	1401	Maternal depression screening	The percentage of children who turned 6 months of age during the measurement year,	Children with documentation of maternal screening or treatment for	Children with a visit who turned 6 months of age in the measurement	National Committee for Quality Assurance	Population/ Public Health

			who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	postpartum depression for the mother.	period.		
CMS74v3	TBD	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	Children who receive a fluoride varnish application	Children, age 0-20 years, with a visit during the measurement period.	Centers for Medicare & Medicaid Services (CMS)	Clinical Process/ Effectiveness
CMS61v3	TBD	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed	Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.	Numerator 1: (High Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period Numerator 2 : (Moderate Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period	Denominator 1: (High Risk) All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent OR 10-Year Framingham Risk > 20% Denominator 2 : (Moderate Risk) All patients aged 20 through 79 years who have 2 or more Major CHD Risk Factors OR 10-Year	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Clinical Process/ Effectiveness

				Numerator 3 : (Low Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period or up to four (4) years prior to the current measurement period	Framingham Risk 10-20% Denominator 3 : (Low Risk) All patients aged 20 through 79 years who have 0 or 1 Major CHD Risk Factors OR 10-Year Framingham Risk <10% ** For Denominator 2 and Denominator 3, Fasting HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)		
CMS64v3	TBD	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)	Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.	Numerator 1: Patients whose most recent fasting LDL-C test result is in good control, defined as <100 mg/dL Numerator 2: Patients whose most recent fasting LDL-C test result is in good control, defined as <130 mg/dL Numerator 3: Patients whose most recent fasting LDL-C test result is in good control, defined as	Denominator 1: (High Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have CHD or CHD Risk Equivalent OR 10 year Framingham risk > 20% Denominator 2: (Moderate Risk)	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Clinical Process/ Effectiveness

				<160 mg/dL	All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have 2 or more Major CHD Risk Factors OR 10 year Framingham Risk 10-20%. Denominator 3: (Low Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed up to 4 years prior to the current measurement period and have 0 or 1 Major CHD Risk Factors OR 10 year Framingham risk <10%. ** For Denominator 2 and Denominator 3, HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)		

CMS149v2	Not Applicable	Dementia: Cognitive Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period	Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period	All patients, regardless of age, with a diagnosis of dementia	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS65v3	TBD	Hypertension: Improvement in Blood Pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Patients whose follow-up blood pressure is at least 10 mmHg less than their baseline blood pressure or is adequately controlled. If a follow-up blood pressure reading is not recorded during the measurement year, the patient's blood pressure is assumed "not improved."	All patients aged 18-85 years of age, who had at least one outpatient visit in the first six months of the measurement year, who have a diagnosis of hypertension documented during that outpatient visit, and who have uncontrolled baseline blood pressure at the time of that visit	Centers for Medicare & Medicaid Services (CMS)	Clinical Process/ Effectiveness
CMS50v2	TBD	Closing the referral loop: receipt of specialist report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.	Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit	Centers for Medicare & Medicaid Services (CMS)	Care Coordination

			provider to whom the patient was referred.		during the measurement period.		
CMS66v2	TBD	Functional Status Assessment for Knee Replacement	Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10 Global Health, PROMIS-29, KOOS) not more than 180 days prior to the primary TKA procedure, and at least 60 days and not more than 180 days after TKA procedure	Adults, aged 18 and older, with a primary total knee arthroplasty (TKA) and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after TKA procedure.	Centers for Medicare & Medicaid Services (CMS)	Patient and Family Engagement
CMS56v2	TBD	Functional Status Assessment for Hip Replacement	Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments	Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10-Global Health, PROMIS-29, HOOS) not more than 180 days prior to the primary THA procedure, and at least 60 days and not more than 180 days after THA procedure.	Adults aged 18 and older with a primary total hip arthroplasty (THA) and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after THA procedure.	Centers for Medicare & Medicaid Services (CMS)	Patient and Family Engagement
CMS90v3	TBD	Functional Status Assessment for Complex	Percentage of patients aged 65 years and older with heart failure who completed initial	Patients with patient reported functional status assessment results (e.g., VR-12;	Adults aged 65 years and older who had two outpatient encounters during	Centers for Medicare & Medicaid Services	Patient and Family Engagement

		Chronic Conditions	and follow-up patient-reported functional status assessments	VR-36; MLHF-Q; KCCQ; PROMIS-10 Global Health, PROMIS-29) present in the EHR at least two weeks before or during the initial encounter and the follow-up encounter during the measurement year.	the measurement year and an active diagnosis of heart failure.	(CMS)	
CMS179v2	TBD	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	Measure Observations statement: Average percentage of time that patients in the measure population have INR results within the therapeutic range (i.e., TTR)	Initial Patient Population statement: Patients aged 18 and older with atrial fibrillation without valvular heart disease who had been on chronic warfarin therapy for at least 180 days before the start of and during the measurement period. Patient should have at least one outpatient visit during the measurement period Measure Population statement: Equals All in Initial Patient Population with sufficient international normalized ratio (INR) results to	Centers for Medicare & Medicaid Services (CMS)	Patient Safety

					calculate a warfarin time in therapeutic range (TTR)		
CMS22v2	TBD	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated	Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive	Percentage of patients aged 18 years and older before the start of the measurement period	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Population/ Public Health

Stage 3 Meaningful Use criteria

2018 Stage 3 program requirements specific to eligible hospitals and EPs attesting to their state's Medicaid EHR Incentive Program, click here.

EHR Reporting Period

- In Program Year **2018**, all providers will once again be attesting to a minimum **90-day** EHR Reporting Period for the Meaningful Use Objectives and Measures.
- The **CQM** reporting period **for Eligible Professionals** who are attesting to Meaningful Use criteria *for the first time* is any continuous **90-day** period between January 1, 2018 and December 31, 2018.
- The CQM reporting period for Eligible Professionals who have successfully demonstrated any stage of Meaningful use in a prior year, is the **full calendar year** from January 1, 2018 through December 31, 2018.

Objectives and Measures

- All providers are required to attest to a single set of objectives and measures.
- For eligible professionals (EPs) and eligible hospitals there are 8 objectives.
  - View the **Stage 3 Specification Sheets** for EPs and Hospitals.

To meet **Stage 3 requirements**, all providers must use technology certified to the 2015 Edition. A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, **if** the mix of certified technologies would not prohibit them from meeting the Stage 3 measures.

Flexibility within Objectives and Measures

Stage 3 includes flexibility within certain objectives to allow providers to choose the measures most relevant to their patient population or practice. The Stage 3 objectives with flexible measure options include**:**

- **Coordination of Care through Patient Engagement** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- **Health Information Exchange** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- **Public Health Reporting** – Eligible professionals must report on two measures and eligible hospitals must report on four measures.

Stage 3 Requirements for Medicaid EHR Incentive Program Resources

- Patient Electronic Access Tip Sheet
- Updated Security Risk Assessment Tool
- Medicaid Eligible Professionals: Public Health and Clinical Data Registry Reporting
- Medicaid Eligible Hospitals: Public Health and Clinical Data Registry Reporting
- Guide for Eligible Professionals Practicing in Multiple Locations
- Health Information Exchange Fact Sheet

8 Enrollment process

In order for providers to meet the qualifications for the Alaska Medicaid EHR Incentive Program providers are required to attest that the information submitted in their application is true and accurate.

In order for an EP or EH to qualify for an incentive payment in a particular calendar year they must have completed their attestation in the SLR within 60 days of the close of the calendar year or alternatively identified attestation period to count towards that payment year (calendar year).

Program attestation preparation

1. Register at the Centers for Medicare and Medicaid Registration and Attestation System at https://ehrincentives.cms.gov/hitech/login.action.
2. Create an SLR account at http://ak.arraincentive.com/.
3. Locate a copy of your signed contract or invoice with a vendor for the purchase, implementation or upgrade of a certified EHR system. This contract or invoice would need to identify the current vendor and version of your EHR.
4. Verify your EHR is certified and is on the list from ONC at https://chpl.healthit.gov
5. EPs must locate your active medical license number and Medicaid ID.
6. EHs must locate the most recent 4 years of cost report data.
7. Determine your Medicaid patient volume you will be reporting for the selected 90 days or greater period.
8. Method of certified EHR technology you will be attesting to - meaningful use.
9. Complete the Eligibility workbook and Adopt/Implement/Upgrade Attestation workbook.
10. Complete the application in the SLR, print, sign and upload the attestation and additional documents into the SLR.

Medicare and Medicaid Registration and Attestation System

The Medicare Attestation Worksheets allow providers to log their meaningful use measures on a document to use as a reference when attesting for the Medicare EHR Incentive Program in CMS' Registration and Attestation system. **Access the 2018 Eligible Hospital, CAH and Dual-Eligible Modified Stage 2 Attestation Worksheet** here **and Eligible Hospital, CAH and Dual-Eligible Stage 3 Attestation Worksheet** here.

NOTE: Medicare EP's will attest to the Advancing Care Information performance category under MIPs. To access the Quality Payment Program and requirements for Medicare eligible clinicians visit the official website.

EPs registering in the Medicaid EHR Incentive Program must enter their National Plan and Provider Enumeration System (NPPES) web user account, user ID and password to log into the registration system. EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong. The EP must select where their payment will go in the payee TIN type. EPs must provide the SSN payee TIN type to indicate that the provider receives the payment. The EIN payee TIN type indicated the group receives the incentive payment. Providers will have to enter the group name, group payee TIN and the group NPI in order for the provider to issue the payment to the group in which they are associated. In order for the group or clinic to receive the incentive payments from Alaska, the EP must have a billing provider contract to which the payment is being assigned.

EPs must select between the Medicare and Medicaid incentive programs. If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the CMS Registration and Attestation System to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment.

Hospital representative must enter their Identification and authentication User ID and Password to log into the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Hospitals must provide their CCN and the NPI for the hospital. The hospital must select the Medicaid state and the hospital type in which they will participate.

EHs seeking payment from both Medicare and Medicaid will be required to visit the Medicare and Medicaid EHR Incentive Program Registration and Attestation System annually to attest to meaningful use before returning to SLR website to complete the attestation for Alaska's Medicaid EHR Incentive Program. Alaska Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The Medicare and Medicaid EHR Incentive Program Registration and Attestation System will electronically notify the Alaska Medicaid SLR of a provider's choice to enroll in the Alaska Medicaid EHR Incentive Program. The information completed by the provider at the national website is sent to the SLR electronically within 24-48 hours.

Below are user guides for Medicaid and Medicare

EPs and EHs. Medicaid User Guide:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHRMedicaidEP_RegistrationUserGuide.pdf

Medicare User guide:
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/QualityNetUserGuide.pdf

Enterprise Identity Data management (EIDM) User Guide:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHRHospital_RegistrationUserGuide.pdf

MIPS Participation & Overview Fact Sheet:

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-MIPS-participation-and-overview-fact-sheet.pd

2018 MIPS Scoring 101 Guide:

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-MIPS-Scoring-Guide.pdf

Alaska Medicaid State Level Registry

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation is provided, the Alaska Medicaid EHR Incentive Program Office will conduct a review to validate that the EP or EH meets the qualifications of the program and will verify supporting documentation.

The attestation itself will require the EP or EH to attest to meeting all requirements defined in the federal regulations. Some documentation will be required to be provided to support specific elements of the attestation. For instance, providers who attest to AIU of certified EHR technology will be required to submit a copy of a signed contract or paid invoice. All providers will be required to mail the originally signed attestation to the Alaska Medicaid EHR Incentive Program Office.

During the first year of the program, EPs or EHs will be able to attest to adopting, implementing or upgrading to certified EHR technology or attest to meaningful use. It should be noted that the documentation for AIU of certified EHR technology for EPs or EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable *if the system and version of EHR technology has been certified by ONC* (the Certified Health IT Product List can be located at ONC's website at https://chpl.healthit.gov all providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

Below is the website to create an account on the State Level Registry
https://ak.arraincentive.com/CreateNewAccount.aspx

Webpage to logon to the State Level Registry
https://ak.arraincentive.com/Login.aspx

9 What is the payment methodology?

Payment methodology for eligible professionals

Payment for EPs equals 85 percent of net average allowable costs or NAAC. NAAC are capped by statute at $25,000 in the first year, and $10,000 for each of 5 subsequent years. NAAC for pediatricians with Alaska Medicaid patient volume between 20-29 percent are capped at two thirds of those amounts respectively. Thus, the maximum incentive payment an EP could receive from Alaska Medicaid equals $63,750, over a period of 6 years, or $42,500 for pediatricians with a 20-29 percent Medicaid patient volume.

Provider	EP	EP-Pediatrician
Patient Volume	30%	20-29%
Year 1	$21,250	$14,167
Year 2	8,500	5,667
Year 3	8,500	5,667
Year 4	8,500	5,667
Year 5	8,500	5,666
Year 6	8,500	5,666
Total Incentive Payments	$63,750	$42,500

Pediatricians may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

Payments for Medicaid eligible professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The TIN must be associated with either the EP directly or a group or clinic with which the EP has a contractual relationship. State of Alaska policy requires a State of Alaska Substitute Form W9 for each payee. If all EPs within a group/clinic assign their payment to the clinic, only one Substitute W9 is required; if the payment is directed to each EP, one Substitute W9 for each EP.

The State of Alaska substitute W-9 may be found at http://doa.alaska.gov/dof/forms/resource/sub_form_w9.pdf

The Alaska Medicaid EHR Incentive program does not include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully using certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year, except in year one in which the provider may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021.

Payment Amount for Year:	First Year Medicaid EP Qualifies to Receive Payment 2011	First Year Medicaid EP Qualifies to Receive Payment 2012	First Year Medicaid EP Qualifies to Receive Payment 2013	First Year Medicaid EP Qualifies to Receive Payment 2014	First Year Medicaid EP Qualifies to Receive Payment 2015	First Year Medicaid EP Qualifies to Receive Payment 2016
2011	$21,250	-	-	-	-	-
2012	$8,500	$21,250	-	-	-	-
2013	$8,500	$8,500	$21,250	-	-	-
2014	$8,500	$8,500	$8,500	$21,250	-	-
2015	$8,500	$8,500	$8,500	$8,500	$21,250	-
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	-	$8,500	$8,500	$8,500	$8,500	$8,500
2018	-	-	$8,500	$8,500	$8,500	$8,500
2019	-	-	-	$8,500	$8,500	$8,500
2020	-	-	-	-	$8,500	$8,500
2021	-	-	-	-	-	$8,500
TOTAL Possible Incentive Payments	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Maximum Incentive Payments for EPs

In the event that the Department of Health and Social Services determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to the State of Alaska in a lump sum, or an accounts receivable account will be created. The existing practice allows the Department of Health and Social Services to work out an acceptable repayment period.

Payment methodology for eligible hospitals

Calculating the overall incentive payment is a multi-step process and utilizes hospital data on total discharges (excluding nursery discharges) to compute a growth rate which is used to determine projected eligible discharges. A base amount of $2,000,000 is added to the eligible discharge amount and a transition factor is applied to arrive at the overall EHR amount. The overall EHR amount needs to be adjusted for charity care before Medicaid's share can be calculated. The aggregate EHR hospital incentive payment is calculated as the product of the [overall EHR amount] times [the Medicaid Share].

Calculating the overall EHR amount is a multistep process, hospitals are required to provide and attest to the following information for the incentive payment to be calculated:

- Total Inpatient Discharges for the most recent 4 fiscal years
- Total Number of Medicaid Inpatient Bed Days
- Total Number of Inpatient Bed Days
- Total Hospital Charges
- Total Charges for Charity Care

This is an example of the steps that will be followed to calculate incentive payments to EHs.

How the Annual Discharge Data is Used

Step 1: Calculating the Average Annual Growth Rate:

To calculate the average annual growth rate the hospital reports the total discharges for the 4 most recent hospital fiscal year cost reports. Total discharges are the sum of all inpatient discharges (excluding nursery discharges).

Fiscal year	Total Discharges	Calculating Annual Growth Rate	Average Annual Growth Rate
2007	**23,500**	2008 - 2007 ÷ 2007 = Growth Rate 24,700 - 23,500 ÷ 23,500 = 5.11%	5.11 + 4.45 + 4.26 = 13.82 ÷ 3 = 4.61%
2008	**24,700**		
2009	**25,800**	25,800 - 24,700 ÷ 24,700 = 4.45%	
2010	**26,900**	26,900 - 25,800 ÷ 2,5800 = 4.26%	

Average Annual Growth Rate **4.61%**

Step 2: Applying the average annual growth rate to the base number of discharges

The number of discharges for the base year of fiscal year 2010 is multiplied by the average annual growth rate of 4.61% (1.0461) to project the number of discharges over the next 3 years:

Projected Inpatient Discharge			
Fiscal year 2010	Fiscal year 2011	Fiscal year 2012	Fiscal year 2013
26,900			
x 1.0461	→ **28,140**		
	x 1.0461	→ **29,437**	
		x 1.0461	→ **30,794**

Step 3: Determine the number of eligible discharges and multiply by the discharge payment amount

1. For the first through the 1,149th discharge, $0
2. For the 1,150th through the 23,000th discharge, $200 per discharge
3. For any discharge greater than the 23,000th, $0

In this example, discharges for each year were greater than both 1,149 and 23,000, so the maximum number of discharges that can be counted are 21,851 (23,000 – 1,149) which then gets multiplied by the $200 per discharge.

Fiscal year	Calculated Discharges	Eligible Discharges	@ $200 Per Discharge	Eligible Discharge Payments
2010	**26,900** (max 23,000 -1,149)	21,851	x $200	$4,370,200
2011	**28,140**	21,851	x $200	$4,370,200
2012	**29,437**	21,851	x $200	$4,370,200
2013	**30,794**	21,851	x $200	$4,370,200

Step 4: Add the Base Year Amount of $2,000,000 per payment year to the eligible discharges payments

Step 5: Multiply the Medicaid Transition Factor to the Eligible Discharge Payment to arrive at the Overall EHR Amount

The transition factor equals 1 for year 1, ¾ for year 2, ½ for year 3 and ¼ for year 4. All four years are then added together.

Step 4						**Step5**			
Fiscal year	Base Year Amount		Eligible Discharge Payments		Total Eligible Discharge Payments		Transition Factor		Overall EHR Amount
2010	$2,000,000	+	$4,370,200	=	$6,370,200	x	1	=	$6,370,200
2011	$2,000,000	+	$4,370,200	=	$6,370,200	x	.75	=	$4,777,650
2012	$2,000,000	+	$4,370,200	=	$6,370,200	x	.50	=	$3,185,100
2013	$2,000,000	+	$4,370,200	=	$6,370,200	x	.25	=	$1,592,550
						Total EHR Amount			**$15,925,500**

How the Total Number of Medicaid Inpatient Bed Days, Total Inpatient Days, Total Hospital Charges and Total Charity Care Charges are used

Step 6: Calculate the Medicaid Share

The next step requires that the Medicaid Share be applied to the total EHR amount. The Medicaid Share is the percentage of Medicaid inpatient bed-days divided by the estimated total inpatient bed days adjusted for charity care. **Note: All inpatient bed day totals should exclude nursery care.** To calculate the Medicaid Share, the hospital will need to provide the following information from the most recently filed cost report. The most recently filed cost report is defined as the hospital costs report ending prior to the start of the current federal fiscal year.

Total of Medicaid Inpatient Bed Days	Total Inpatient Days	Total Hospital Charges	Total Charity Care Charges
7,251	21,250	$135,500,000	$12,300,000

The "Medicaid Share", against which the overall EHR amount is multiplied, is essentially the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients. More specifically, the Medicaid share is a fraction expressed:

$$\text{Medicaid Inpatient Bed Days} \div \text{Total Inpatient Days} \times \left(\frac{\text{Total Hospital Charges - Charity Care Charges}}{\text{Total Hospital Charges}}\right)$$

(Total Hospital Charges – Charity Care Charges) ÷ Total Hospital Charges = Charity Care Adjustment

Total Hospital Charges – Charity Care Charges		Total Charges less Charity Care Charges		Total Hospital Charges		Charity Care Adjustment
$135,500,000 - $12,300,000	=	$123,200,000	÷	$135,500,000	=	.909

Total Inpatient Days x Charity Care Adjustment

Total Inpatient Days		Charity Care Adjustment		Adjusted Inpatient Days by Charity Care
21,250	x	.909	=	19,316

Medicaid Inpatient Bed Days ÷ Adjusted Inpatient Days

Total of Medicaid Inpatient Bed Days		Adjusted Inpatient Days		Medicaid Share
7,251	÷	19,316	=	.3754
		Medicaid Share Percentage 37.54%		

Step 7: Calculate the Aggregate Incentive Payment Amount

To arrive at the aggregate incentive amount multiply the overall EHR Amount of $15,925,500 by the Medicaid Share of 37.54%.

15,925,500 X .3754 = $5,978,433

Total Incentive Payment Amount	**$5,978,433**

Step 8: Distributed over 3 Incentive Payments

The Department will issue hospital incentive payments in 3 incentive payment amounts. The following illustrates an example of how the payments will be issued in 3 payment years at 50, 40 and 10% respectively. The hospital would need to continue to meet the eligibility requirements and meaningful use criteria in all incentive payment years. Participate does not have to be in consecutive years until 2016.

Incentive Payment Timeline	Payment Amounts
Year 1 - 50%	**$2,989,216.50**
Year 2 - 40%	**$2,391,373.20**
Year 3 - 10%	**$597,843.30**

Payments for Medicaid eligible hospitals

EH payments will be made in alignment with the calendar year and an EH **must begin** receiving incentive payments no later than FFY 2016. EHs will assign the incentive payments to a tax ID (TIN) in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The hospital in which the payment will be issued will be required to provide Alaska Medical Assistance with a State of Alaska Substitute Form W-9 to which the payment will be issued.

The State of Alaska Substitute W-9 may be found at: http://doa.alaska.gov/dof/forms/resource/sub_form_w9.pdf

For each year a hospital wishes to receive a Medicaid incentive payment, a determination must be made that the hospital was a meaningful user of EHR technology during that year, except in year one in which the hospital may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Alaska Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program. Medicaid EHs are not required to participate on a consecutive annual basis, however, the last year a hospital may begin receiving payments is 2016, and the last year the hospital can receive payments is 2021.

Alaska Medical Assistance currently requires that all hospitals to submit a valid NPI as a condition of Alaska Medicaid provider enrollment. Each hospital will be enrolled as an Alaska Medical Assistance provider and will therefore, meet the requirement to receive an NPI.

In the event that Department of Health and Social Services determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to the State of Alaska in a lump sum, or an accounts receivable account will be created. The existing practice allows the Department of Health and Social Services to work out an acceptable repayment period.

10 Validation and Approval Process

Requesting payment

Once the attestation process is complete the Alaska Medicaid EHR Incentive Program Office will validate that the provider meets all of qualifications for the program.

If additional information is needed to support the attestation, the Alaska Medicaid EHR Incentive Program Office may request any missing or additional information from the provider. If missing or additional information is required, the program office will notify the provider by electronic mail of the specific information needed. A provider must submit the additional information to the program office no later than 30 days after the date of the electronic mail notice. If the provider fails to submit the required information during that period, the department will determine the registration incomplete, although the program office will work with the provider office to complete the application.

Before determining if the provider meets the requirements of the program, the EHR Incentive Program Office will evaluate the facts to which the provider has attested and may request additional information from sources other than the provider to validate the providers attestation submitted.

Upon completion of the attestation process, the EHR Incentive Program Office will review and validate the attestation. If all criteria are met and passed an incentive payment will be approved. The State of Alaska will issue the payment to the tax ID identified in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The same payee information must be input on the Substitute W9 form.

If the EHR Incentive Program Office determines that the provider does not meet the requirements of the program the provider will be notified by letter of the reason for denial. The provider will be notified of their right to request an appeal. If a change occurs in the information that the department used to deny participation, or that previously resulted in a failure to receive CMS validation, the provider may submit a new or updated attestation at any time during that payment year.

Administrative Appeals

Administrative appeals of decisions related to the Alaska EHR Incentive Payment program will be handled under the procedures described in the Alaska Medicaid EHR Incentive Program Regulations.

A provider may appeal the department’s decision to do any of the following:

- deny participation in the Alaska Medicaid electronic health records incentive program under 7 AAC 165.030;
- suspend an incentive payment under 7 AAC 165.050;
- require repayment of all or a portion of an incentive payment under 7 AAC 165.050;
- terminate participation in the Alaska Medicaid electronic health record incentive program under 7 AAC 165.050.
- terminate or suspend participation in the Medicaid program in this state under 7 AAC165.050

To appeal a decision of the program office a provider must submit a written request for a first-level appeal to the EHR Incentive Program Office no later than 30 days after the date of the EHR Incentive Program Office letter denying participation. The request for a first-level appeal must specify the basis upon which the department's decision is challenged and include any supporting documentation. A first-level appeal will be conducted by the State Health Information Technology Coordinator

Upon receipt of a request for a first-level appeal, if the department has suspended an incentive payment, the department may continue suspending the payment until a final determination is made regarding the appropriateness of the suspension. The department will notify the provider in writing of the department's first-level appeal decision.
The first level appeal may be sent to:

Department of Health & Social Services
Health Information Technology Office
Attn: State Health Information Technology Coordinator
3601 C Street, Suite 902
Anchorage, AK 99503

A provider who is not satisfied with the first-level appeal decision may request a second-level appeal by submitting a written request to the DHSS Commissioner no later than 30 days after the date of the first-level appeal decision.

The request for second-level appeal must include:

- a copy of the department's first-level appeal decision;
- a description of the basis upon which the decision is being appealed;
- a copy of the first-level appeal submitted by the provider; and
- Any additional supporting documentation that supports the basis upon which the provider is making the appeal.

The Commissioner's review of the original appeal record, decision, and any additional material submitted by the provider and the department constitutes the second-level appeal. A decision by the Commissioner under this subsection is the final administrative decision of the department. The department will notify the provider of the provider's right to appeal to the superior court under the Alaska Rules of Appellate Procedure.
This request must be submitted to:

Office of the Commissioner
Department of Health and Social Services
Attn: Alaska Medicaid EHR Incentive Program Appeals
P.O. Box 110601
Juneau, Alaska 99811-0601

Program Integrity

The department will conduct regular reviews of attestations and incentive payments. These reviews will be selected as part of our current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Be sure to retain supporting documentation for information you report for the incentive program for the standard IRS business retention (approximately 7 years)

Payment recoupment

In the event of a recoupment, the provider will be notified by letter of the request for recoupment, along with the provider’s right to appeal the decision. When an erroneous payment occurs which results in an overpayment, repayment options will be discussed with the provider. A provider has an option to refund the full payment in one payment or in multiple segments; the final decision is made by the department. The refund will be made to the State of Alaska. The provider can send payment in full to:

State of Alaska
Program Integrity Unit
PO Box 240249
Anchorage, AK 99524

11 Definitions for the EHR Incentive Program

Acceptable documentation means satisfactorily completed written evidence of an approved phase of work or contract and acceptance of the evidence thereof by Alaska Medicaid. Acceptable documentation will refer to the certified EHR technology by name and will include financial and/or contractual commitment. Document date does not have to be within the preceding fiscal year, if the reported version of the EHR technology was certified after the document date. See examples below:

- Copy of contract
- Copy of invoice
- Copy of receipt
- Copy of purchase agreement
- Copy of user license agreement

Acute care hospital means a health care facility— (1) Where the average length of patient stay is 25 days or fewer; and (2) With a CMS certification number (previously known as the Medicare provider number) that has the last four digits in the series 0001–0879 or 1300–1399; or (3) Critical Access Hospitals

Adopt, implement, or upgrade (AIU) means— (1) Acquire, purchase, or secure access to certified EHR technology (proof of purchase or signed contract will be an acceptable indicator); (2) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or (3) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Children's hospital means a separately certified children's hospital, either freestanding or hospital-within hospital that— (1) Has a CMS certification number, (previously known as the Medicare provider number), that has the last 4 digits in the series 3300–3399; and (2) Predominantly treats individuals less than 21 years of age.

Hospital-Based means a professional furnishes ninety percent (90%) or more of their Alaska Medicaid-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or emergency Room, through the use of the facilities and equipment of the hospital; verified by MMIS claims analysis.

Meaningful Use is using certified electronic health record (EHR) technology to: Improve quality, safety, efficiency, and reduce health disparities, engage patients and family, improve care coordination, and population and public health.

Medicaid Encounter for an EP means services rendered to an individual on any one day where:

- Medicaid paid for part or all of the service; or
- Medicaid paid all or part of the individual's premiums, copayments, and cost-sharing
- Claims denied because the Medicaid beneficiary has maxed out the service limit, or
- Claims denied because the service wasn't covered under the State's Medicaid Program, or
- Claim paid at $0 because another payer's payment exceeded the Medicaid payment, or
- Claim denied because the claim wasn't submitted timely

Medicaid Encounter for an EH For purposes of calculating EH patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims. Zero pay claims include:

- Claims denied because the Medicaid beneficiary has maxed out the service limit
- Claims denied because the service wasn't covered under the State's Medicaid Program
- Claim paid at $0 because another payer's payment exceeded the Medicaid payment
- Claim denied because the claim wasn't submitted timely.

Medicaid Management Information System (MMIS) means the Medicaid claims payment system.

Needy individuals mean individuals that meet one of following:

- Were furnished medical assistance paid for by Title XIX Medicaid or Title XXI Children's Health Insurance Program funding including Alaska Medicaid, out-of-state Medicaid programs, or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Were furnished uncompensated care by the provider; or
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay

Patient volume means the proportion of an EPs or EHs patient encounters that qualify as a Medicaid encounter. This figure is estimated through a numerator and denominator and is defined as:

- [Total (Medicaid) patient encounters in any representative continuous 90-day or greater period in the preceding calendar year or in the 12 months immediately preceding the attestation date/Total patient encounters in that same 90-day or greater period] * 100

Pediatrician means a Medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must (1) hold a valid, unrestricted medical license, **and** (2) hold a board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP).

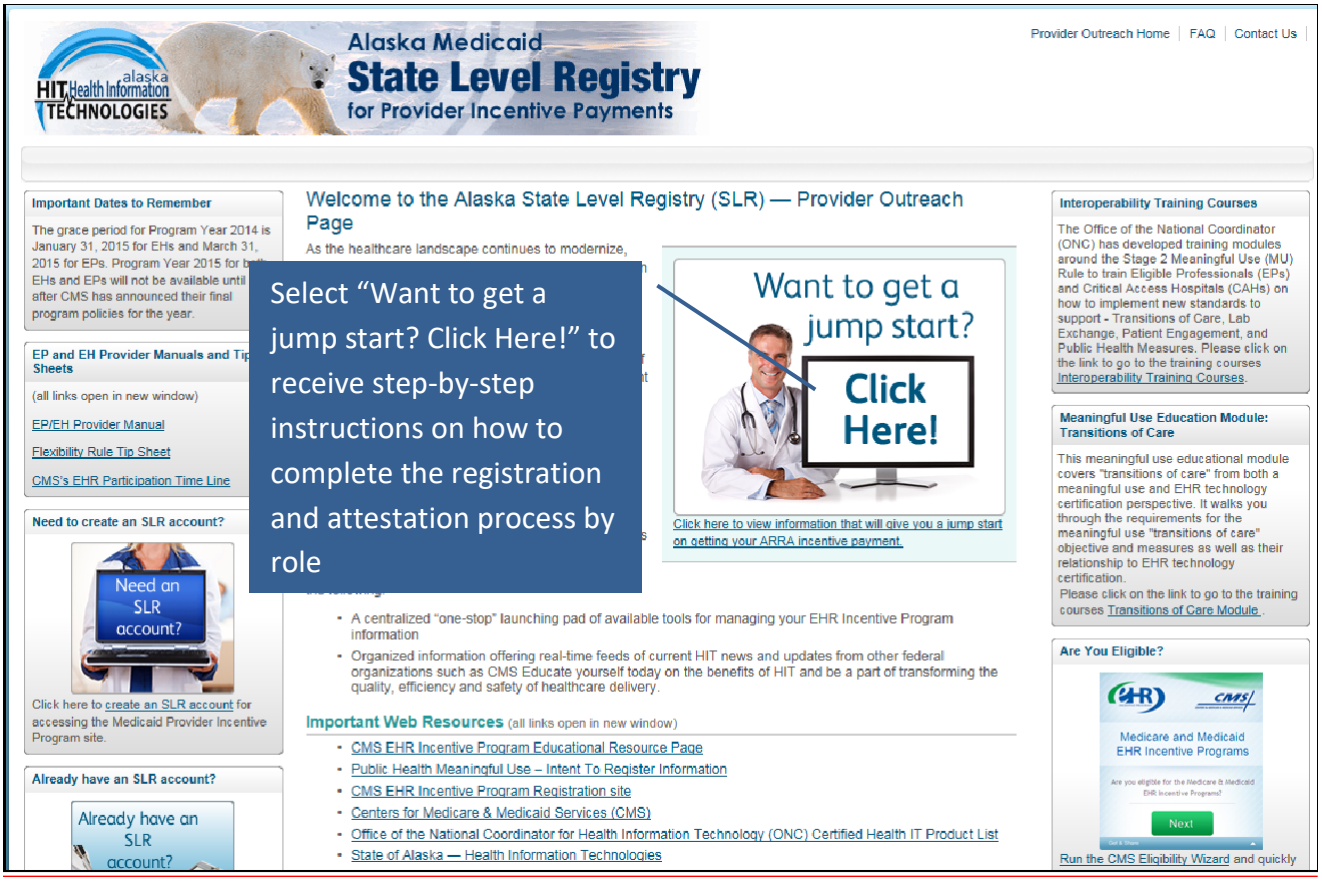
Practices predominantly means an EP for whom more than 50 percent of his or her total patient encounters occur at a federally qualified health center or rural health clinic. The calculation is based on a period of 6 months in the most recent calendar year.

State Medicaid HIT Plan (SMHP) means a document that describes the State's current and future HIT activities.

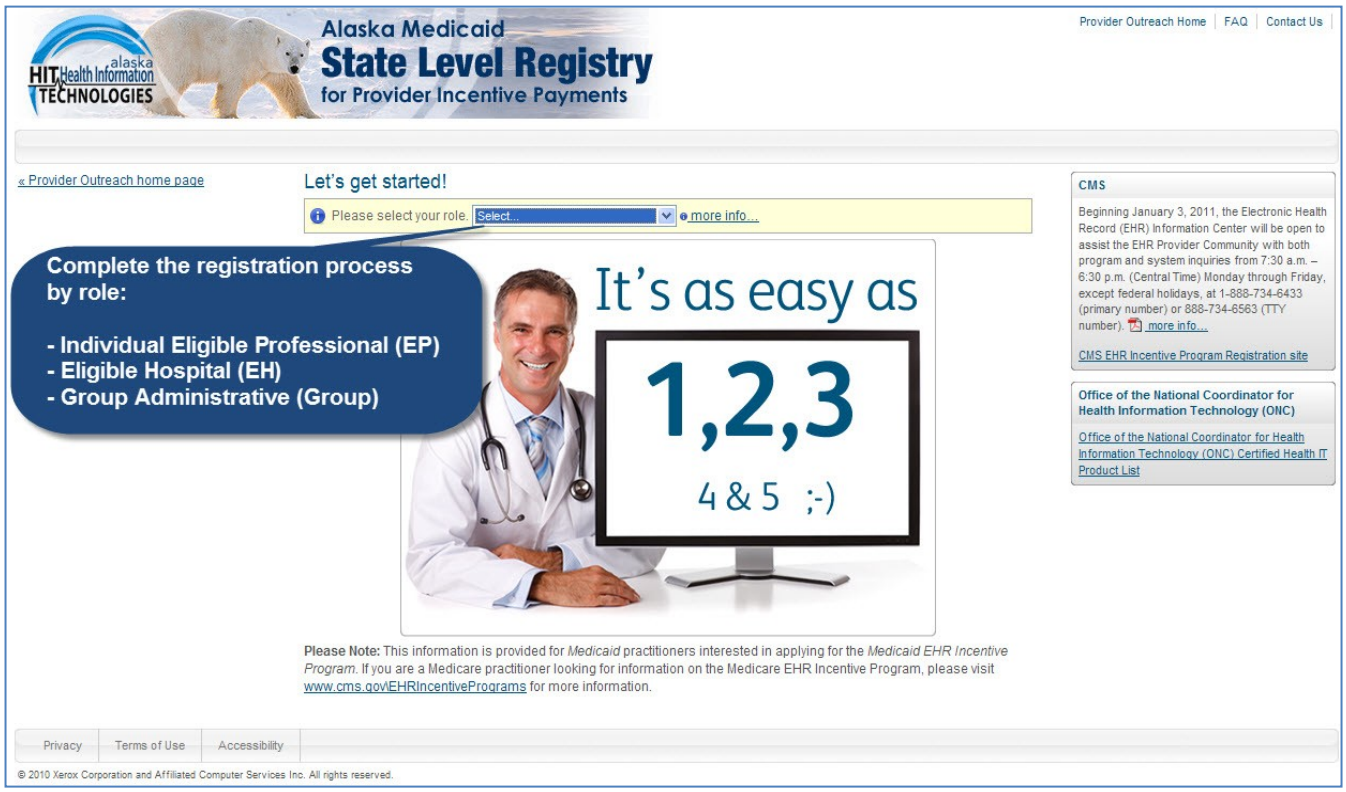
12 State Level Registry Provider Registration

Once the CMS registration information is received in the SLR the provider may complete the registration process in the SLR web portal. The Alaska Medicaid EHR Incentive Program will utilize the secure Alaska Medicaid SLR to house the attestation system.

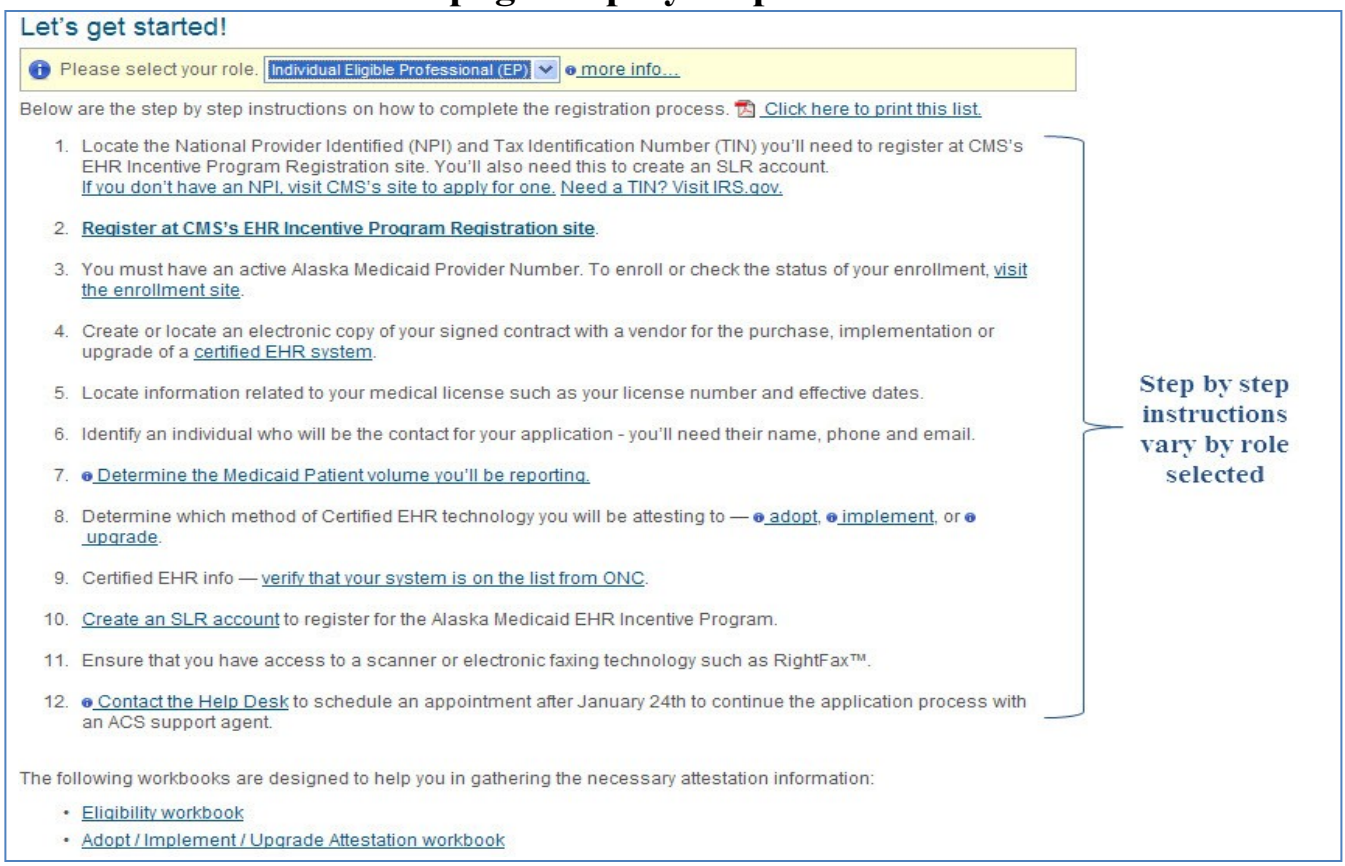
SLR Provider Outreach page -Want to get a jump start?



SLR Provider Outreach page-Select your Role (cont.)

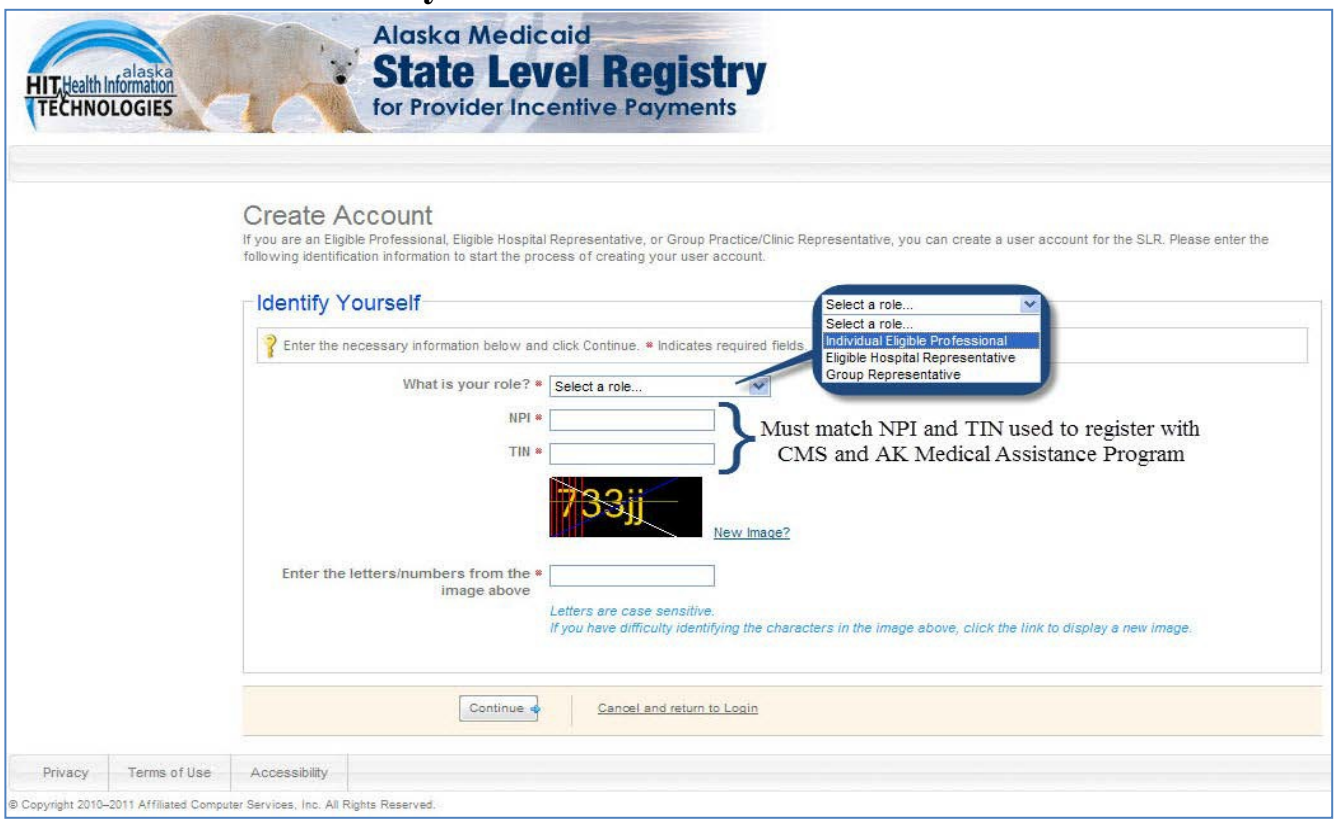


SLR Provider Outreach page-Step by Step Instructions

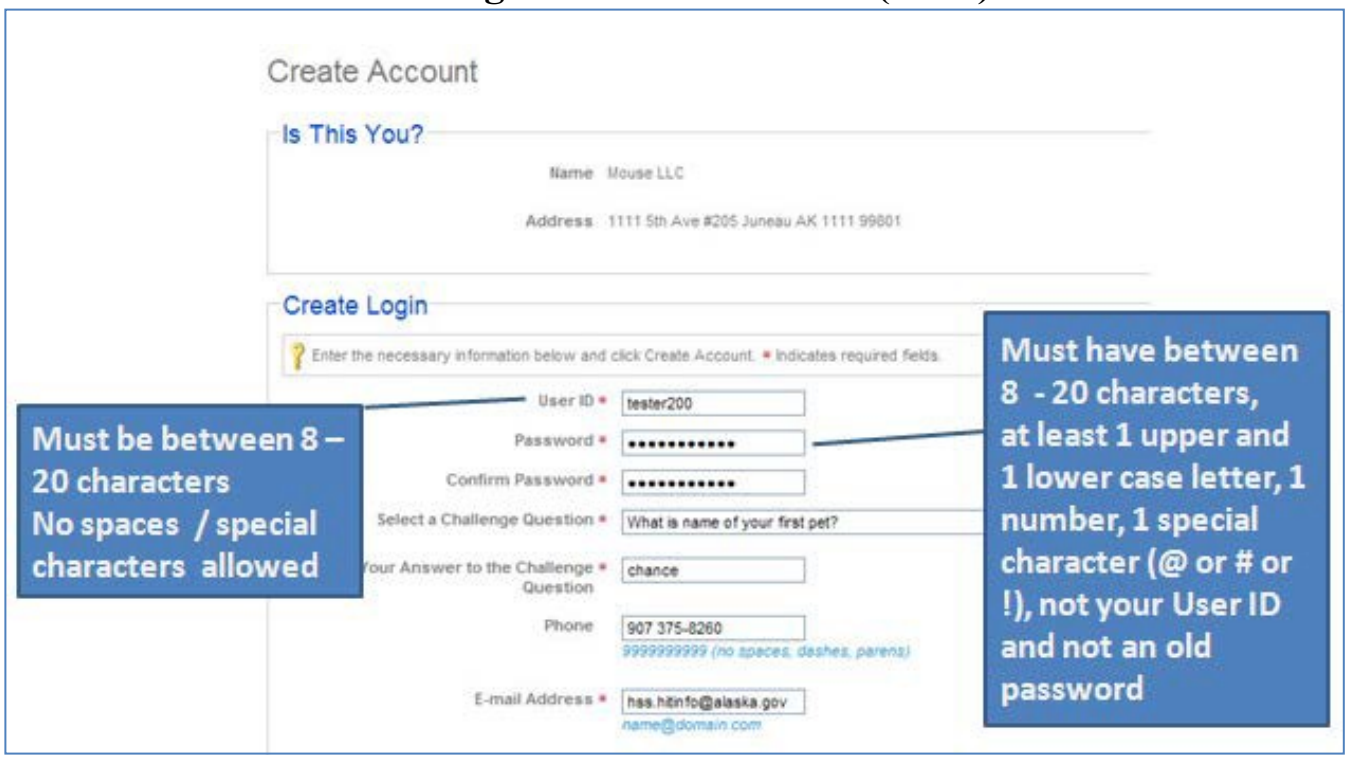


Create Account-SLR Registration (cont.)

Create Account-Identify Yourself



Create Account-Create Login ID and Password (cont.)

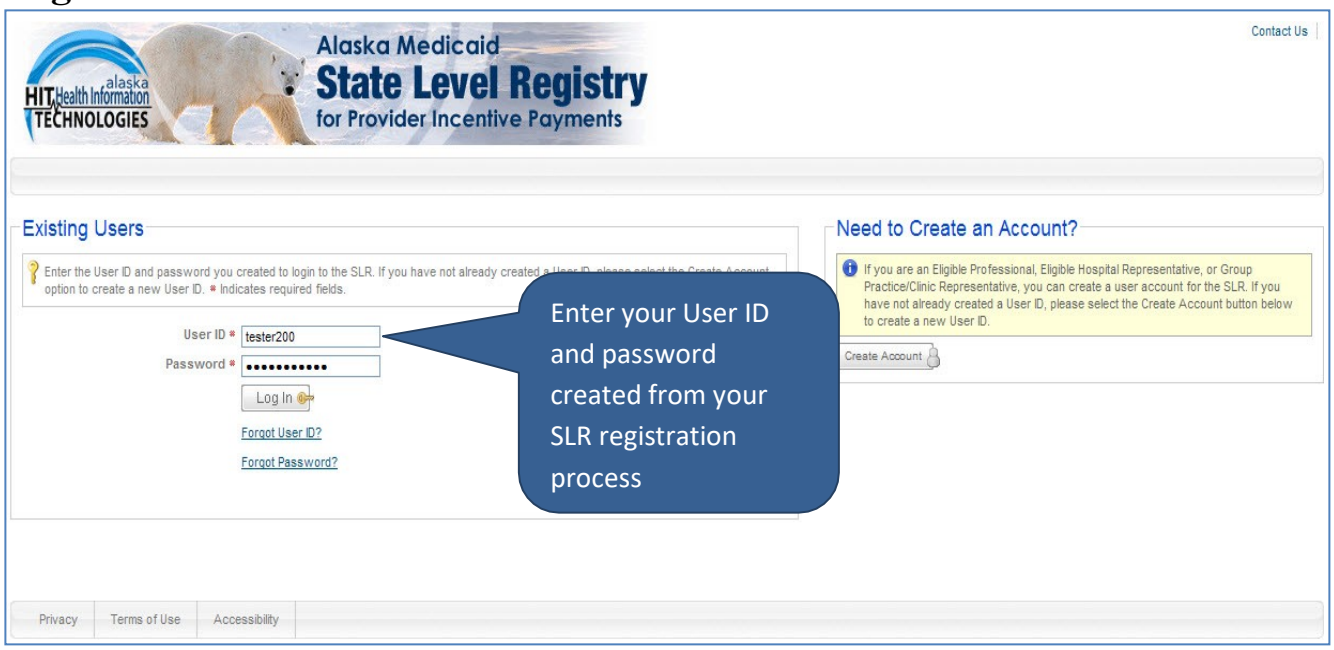


13 State Level Registry Provider Attestation

Eligible Professional and Hospital Provider SLR Attestation

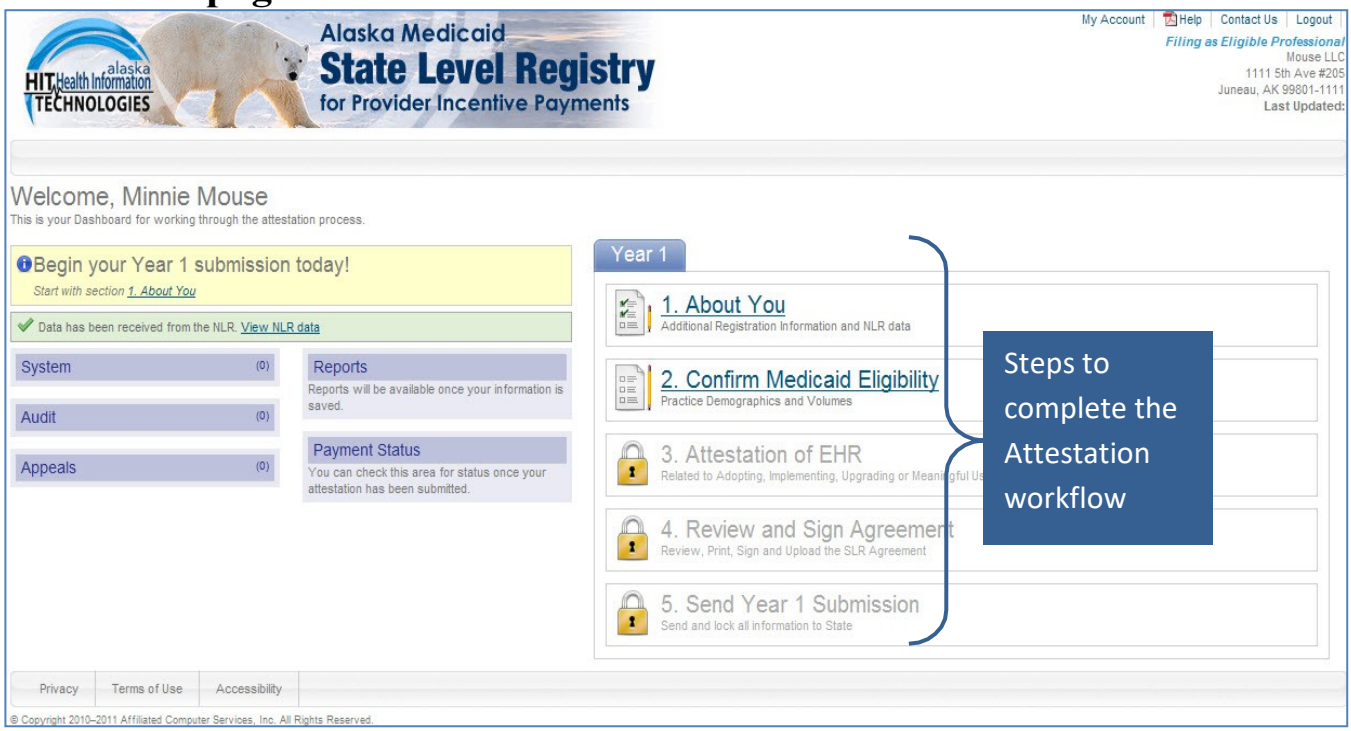
The attestation is an amendment and becomes part of the to the provider's contract. Following are descriptions of the information that a provider will have to enter into the SLR and attest to upon completion of the application.

Login to the SLR



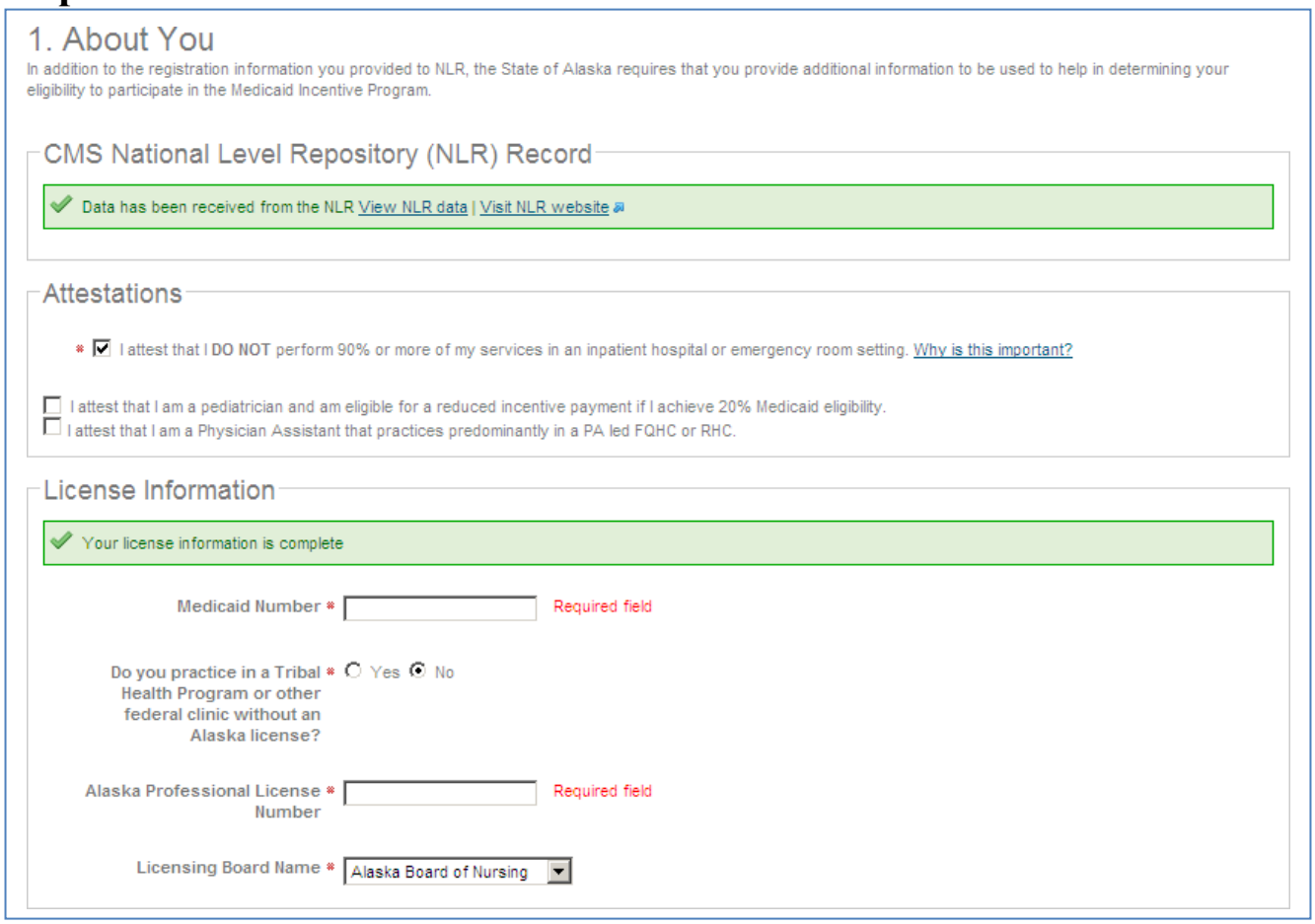
End User License Agreement and Terms of Use Agreement

SLR home page



The SLR home page is known as the Dashboard, which displays basic system and account management information, provider reports, and identifies the steps for attestation. On the Dashboard you can open the Help guide which provides detailed instructions on how to complete the SLR application.

Step 1-About You-EP



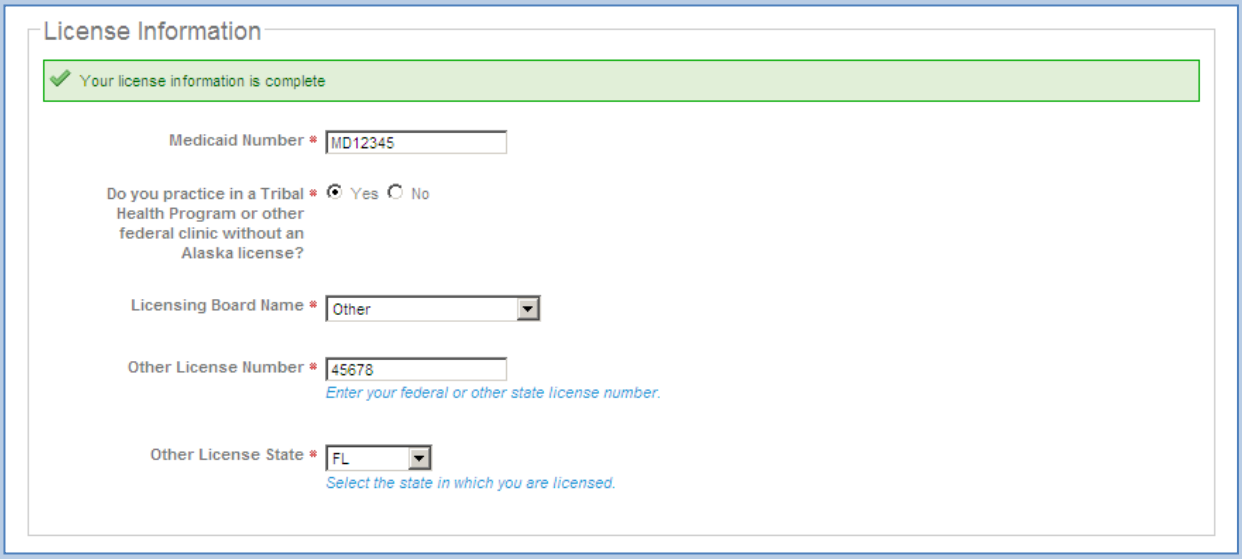
- **CMS National Level Repository (NLR) Record**- Identifies if your CMS registration data has been received.
- **Hospital based attestation**- Eligible professional may not be hospital based to qualify for the program. Eligible professionals are considered hospital based if 90% of more of their services are rendered in an inpatient or emergency room setting. If they are not hospital based, providers they must attest that they DO NOT perform 90% or more of their services in an inpatient hospital or emergency room setting.
- **Pediatrician attestation**-A pediatrician who is qualifying for the program at the minimum 20% Medicaid patient volume must attest that they are a pediatrician and are eligible to receive a reduced incentive payment amount if they achieve 20% Medicaid eligibility. Doctors who qualify as pediatricians may receive a reduced incentive payment if they achieve between 20%-29% Medicaid patient volume.
- **Physician Assistant attestation**-Physician assistants may only qualify for the Medicaid EHR Incentive Program if they practice in a FQHC or RHC that is led by a physician assistant, they must attest the they are a physician assistant that practices predominantly in a PA led FQHC or RHC and attached auditable documentation to who the EP meets the definition of a PA in a PA-led facility.
- **License Information**-EPs must enter their Alaska Medicaid provider number, their Alaska professional license number and select the licensing board name. Eligible professionals must identify if they practice in an IHS clinic without an Alaska license.

Step 1-About You-EP (cont.)

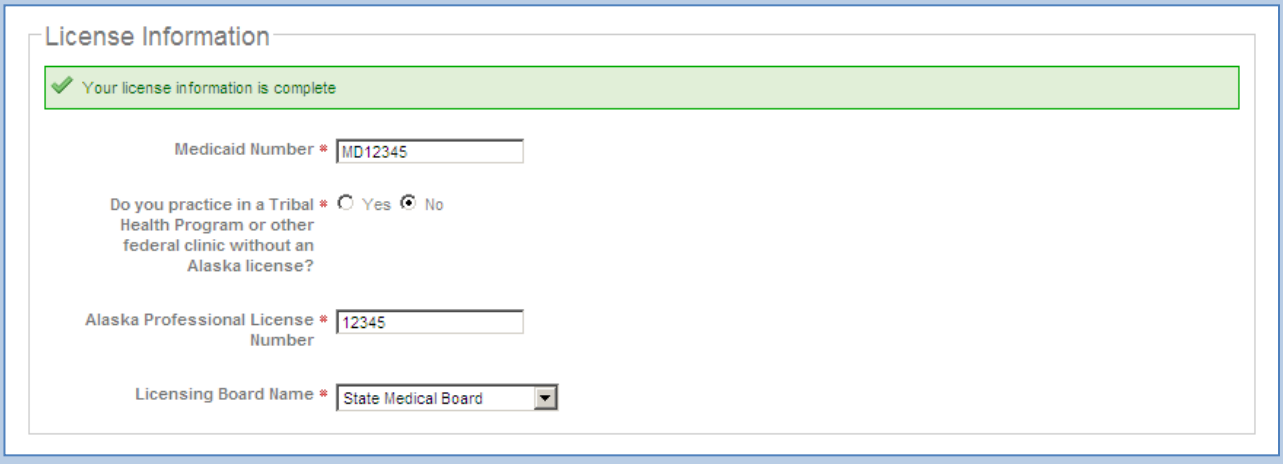
Practice in an IHS Clinic or Tribal Clinic

- **Practice in Indian Health Clinic**-EPs must identify if they practice in a Tribal clinic or other federal clinic without an Alaska license.
- **Other License Number and State**-If the EP practices in an IHS/Tribal clinic and does not have an Alaska professional license they must select the licensing board name and must enter the other professional license number and the state in which they were licensed in the Other License Number and Other License State data fields. If the provider is only licensed in Alaska then they must enter their Alaska Professional license number.

Licensed in another State

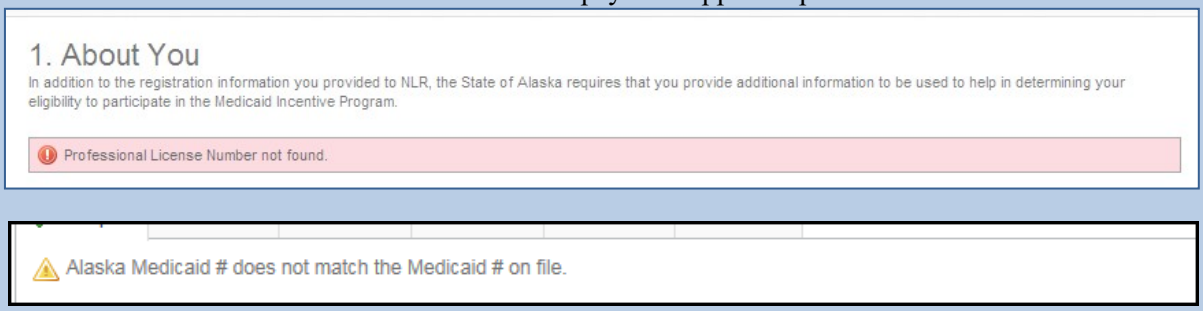


Alaska Professional License Number

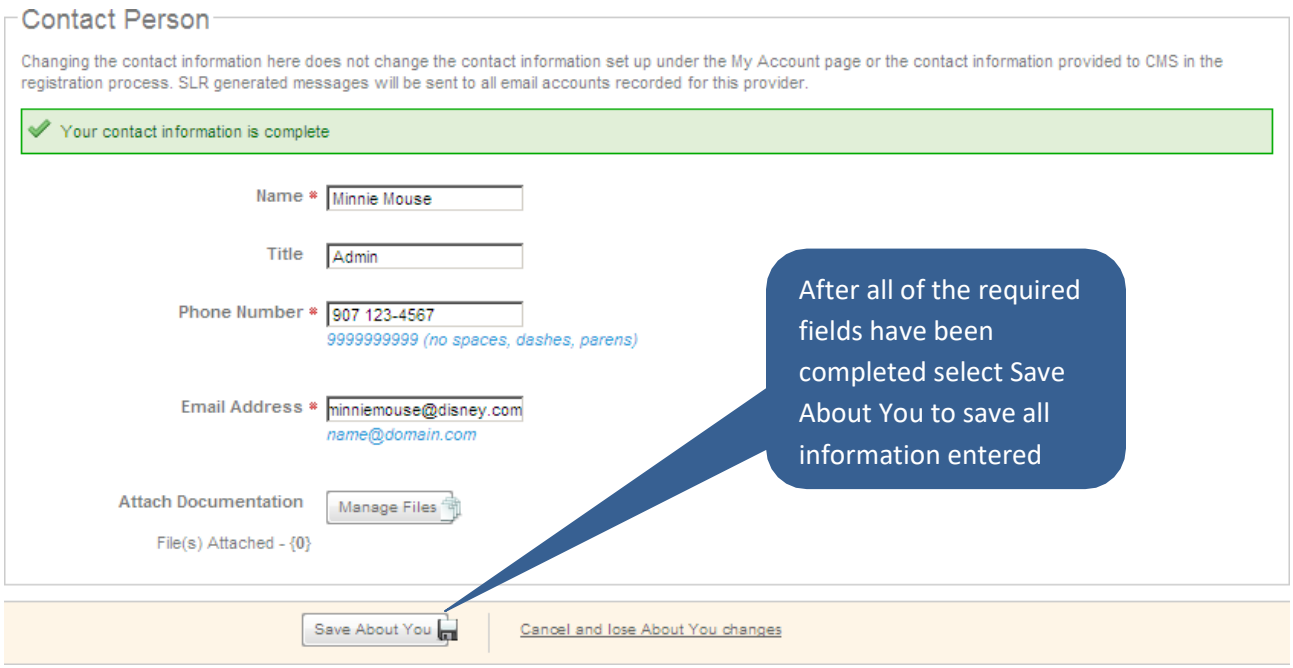


Step1-About You-License Information-EP (cont.)

Note: If you receive a message Professional License Number not found or a yellow triangle stating the Alaska Medicaid # doesn't match the Medicaid # on file, you may still proceed to the next step of the application. Your professional license number will be validated at the payment approval process.

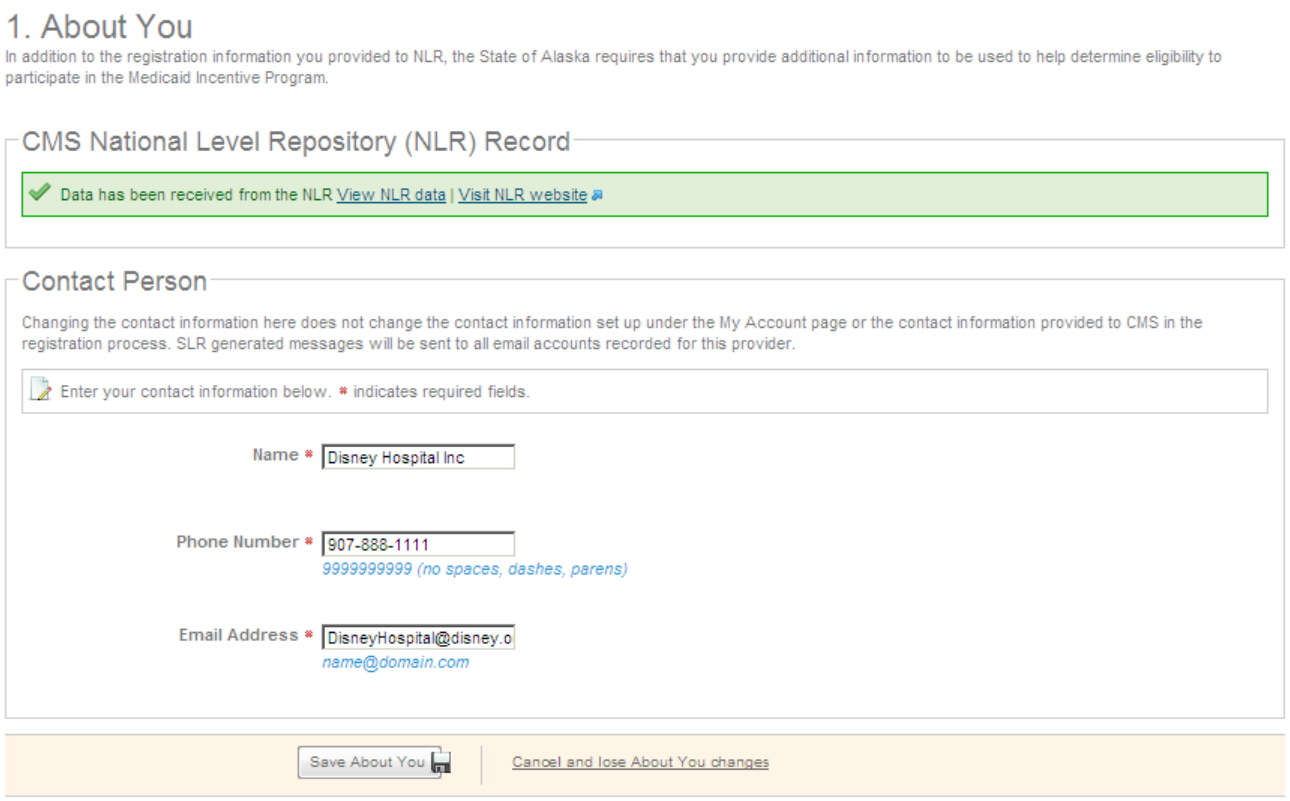


Step 1-About You-EP (cont.)



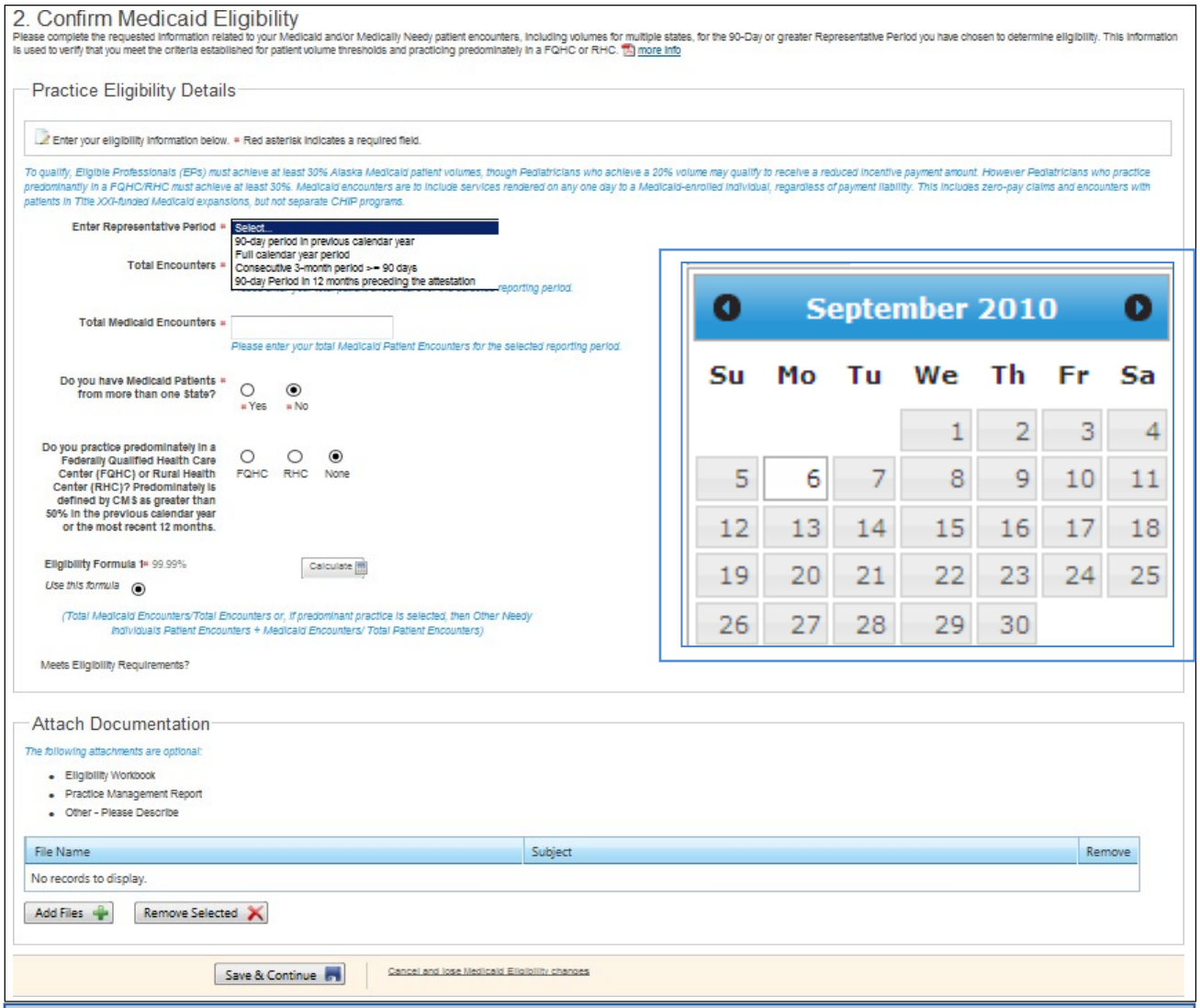
- **Contact Person**-EPs may identify another contact person name phone number and email address who may be contacted if there are any issues with your attestation in addition to the contact information set up under the My Account page.

Step 1-About You-EH



- **Contact Person**-EHs may identify another contact person name phone number and email address who may be contacted if there are any issues with your attestation in addition to the contact information set up under the My Account page.

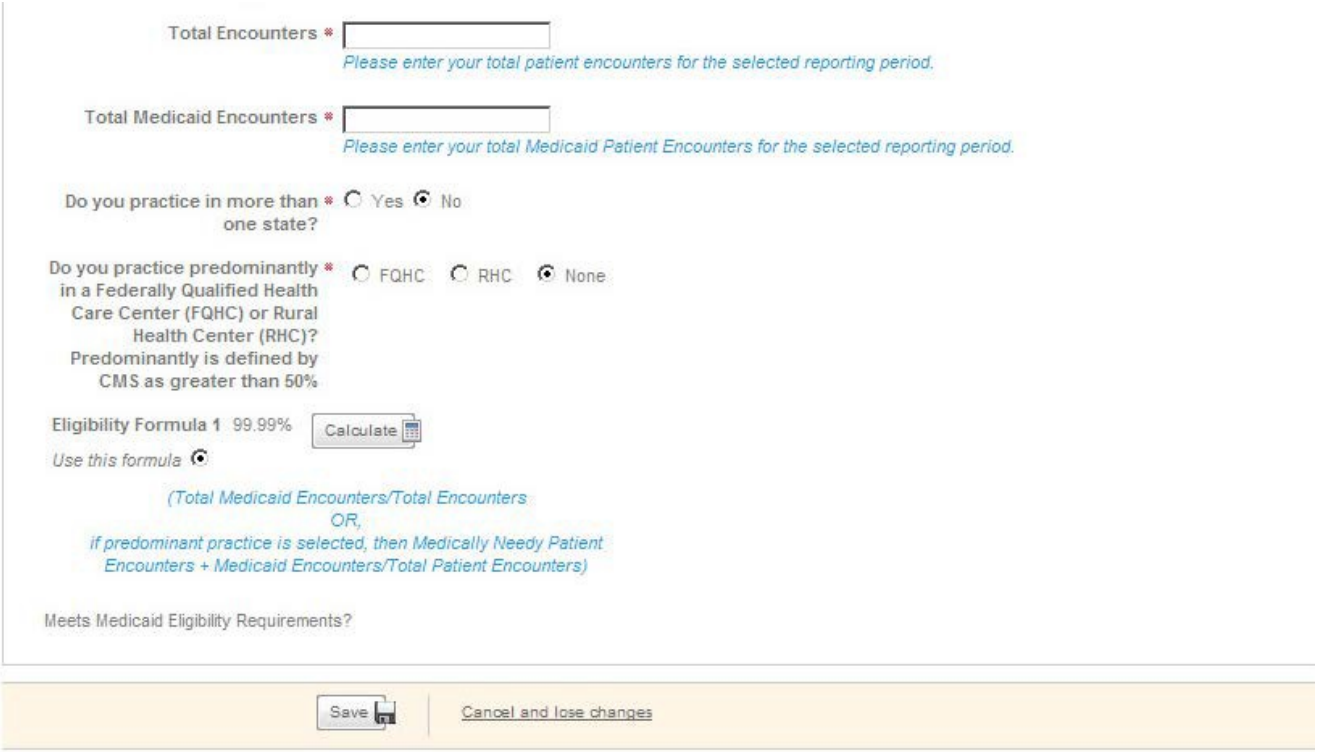
Step 2-Confirm Medicaid Eligibility-EP



- **Enter the Start date of your 90-day or greater period**-The provider must select from thecalendar the start date for the 90 days or greater representative period use to enter the patient volume data.

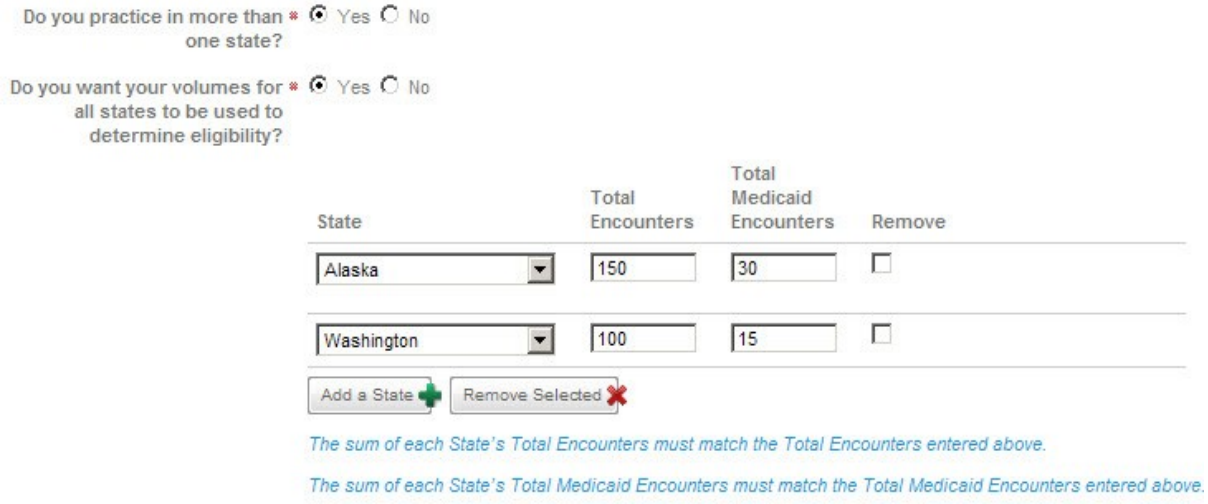
- The choices:
  - **90 day period** - you must select the start date of the selected 90 day period from the preceding calendar year and the SLR will calculate the end date
  - **In any 3 month period in the preceding year that is 90-days or greater**
  - **Full preceding calendar year period** - you must enter the start date of January 1st of the previous calendar year and the SLR will calculate the end date
  - **90-day period in 12 months preceding the attestation**

Step 2-Confirm Medicaid Eligibility-EP (cont.)



- **Total Encounters**- Enter the total number of encounters for the selected representative period.
- **Total Medicaid Encounters**- Enter the total number of unique Medicaid encounters for the same representative period.
- **Do you practice in more than one state?** The eligible professional must identify if they practice in more than state. If the eligible professional does not practice in more than one state they may proceed to the next question. If the EP selects yes, they will have the option of using the Medicaid patient volume from the other state, although they are not required to use the out of state Medicaid patient volume.

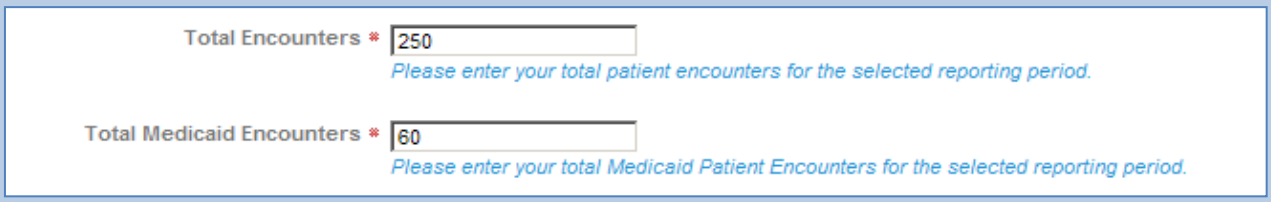
Step 2-Confirm Medicaid Eligibility-EP (cont.)



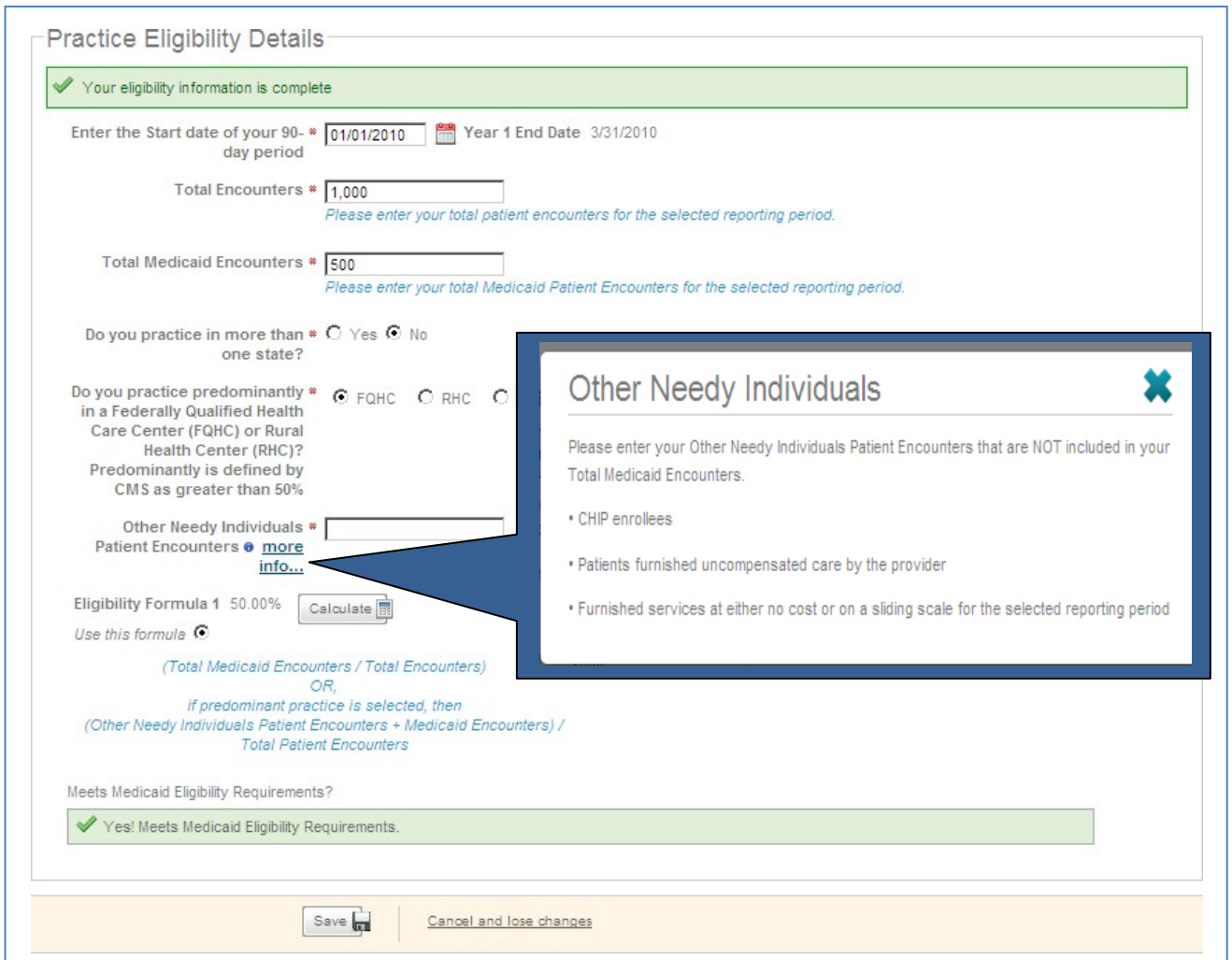
Other State Encounters

Do you want your volumes for all states to be used to determine eligibility?-If the EP identifies that they practices in more than one state they must identify if they want to use the Medicaid and total encounters from that state. If they select yes, they will be asked to enter the State, the total encounters from that state and the total Medicaid encounters for that state.

Note: If the EP uses the other states encounter volume they are required to enter the number of Medicaid encounters and total encounters for each of the states in which they practice, including Alaska, in these date fields. The total encounters and total Medicaid encounters entered in these fields must match the total encounters and total Medicaid encounters entered in the initial patient volume data entry.



Step 2-Confirm Medicaid Eligibility-EP (cont.)

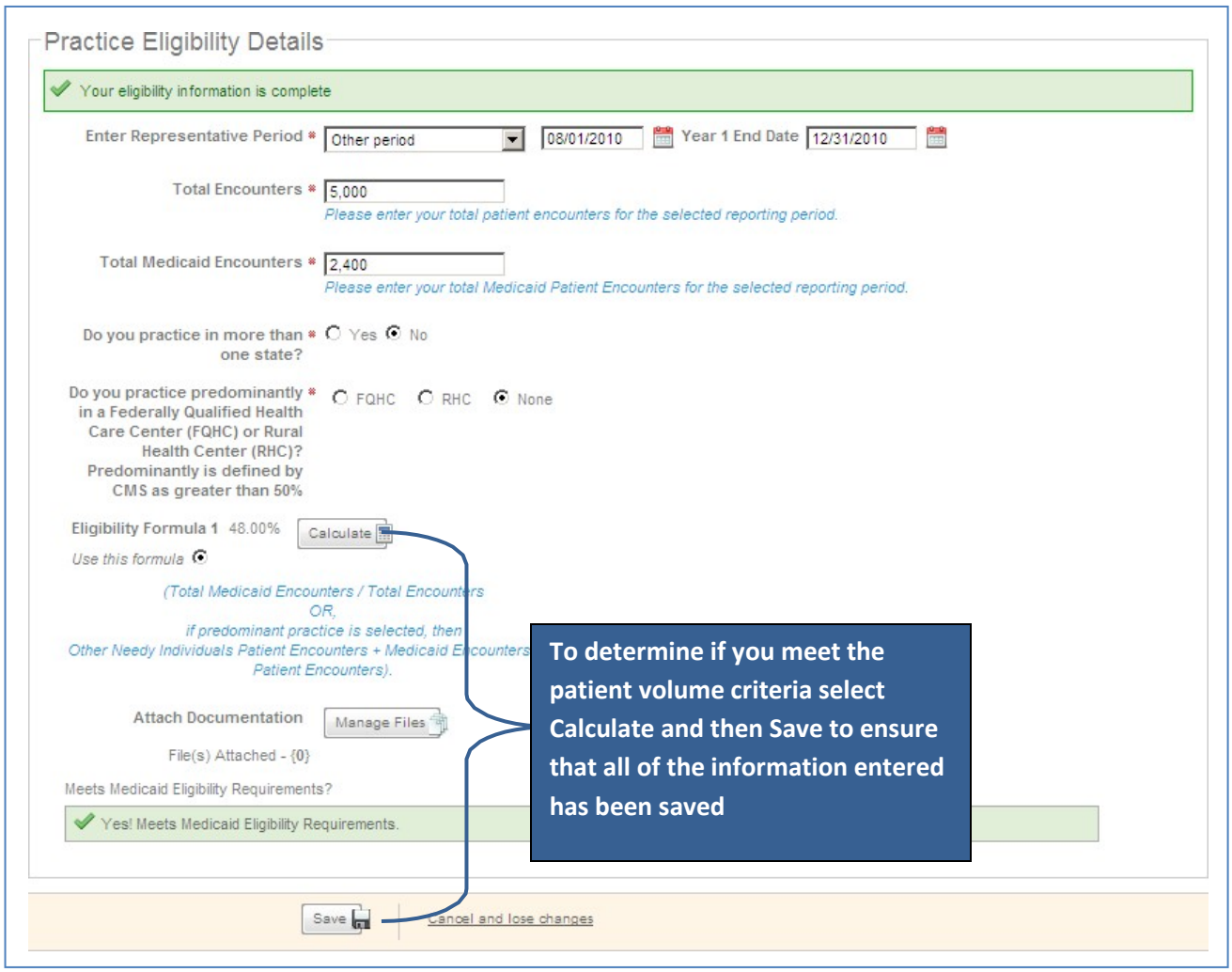


EP Practicing Predominantly in a FQHC or RHC

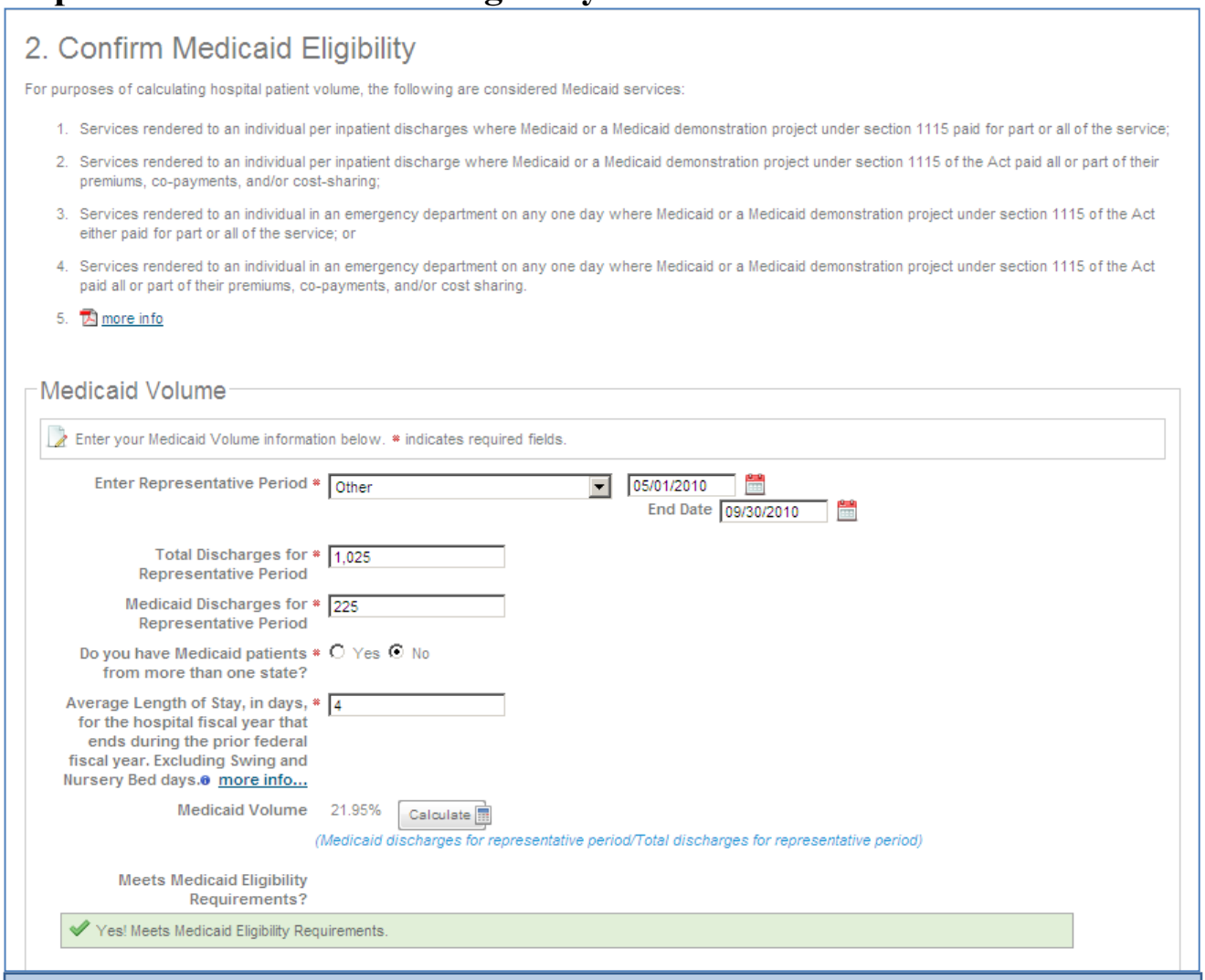
- **Needy Individual Patient Encounters**-Medicaid EPs practicing predominantly in a FQHC or RHC may use a needy individual patient volume. In the SLR the EP must enter the total number of needy individual encounters that are not included in the Total Medicaid Encounter volume entered in the initial patient volume data entry.

- **Practicing predominantly-** An EP practices predominantly in a FQHC or RHC when the clinical location is over 50% of the EPs total patient encounters over a 6 month time period.

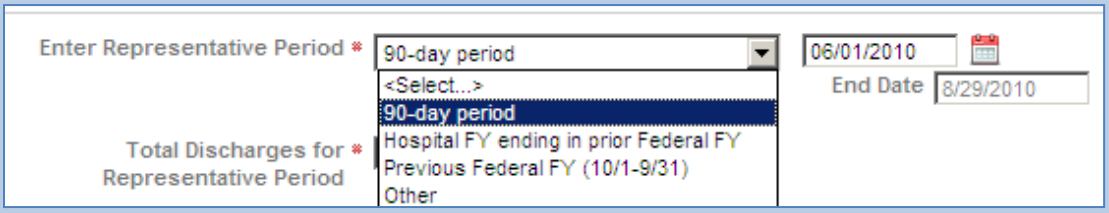
Step 2-Confirm Medicaid Eligibility EP-Complete (cont.)



Step 2-Confirm Medicaid Eligibility-EH

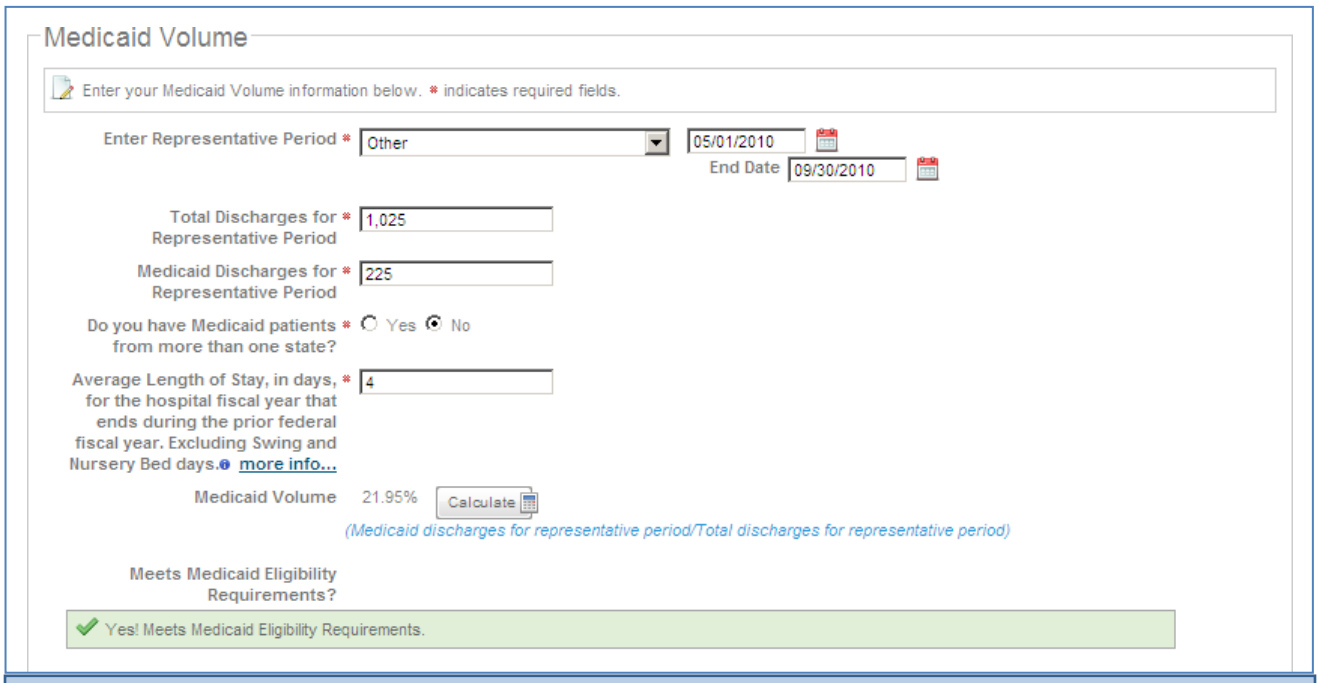


Enter Representative Period



- Select a 90 day or greater period to enter the hospital patient encounter information to establish the patient volume calculation.
- If the hospital selects a:
  - **90 day period**-you must select the start date of the selected 90 day period
  - **Hospital FY ending in the prior Federal FY**- you must enter the start date of the hospital fiscal year that end of the previous federal fiscal year of September 30th
  - **Previous Federal FY-** (10/1-09/30)
  - **Other period**-the period must be greater than 90 day and must be within the previous federal fiscal year

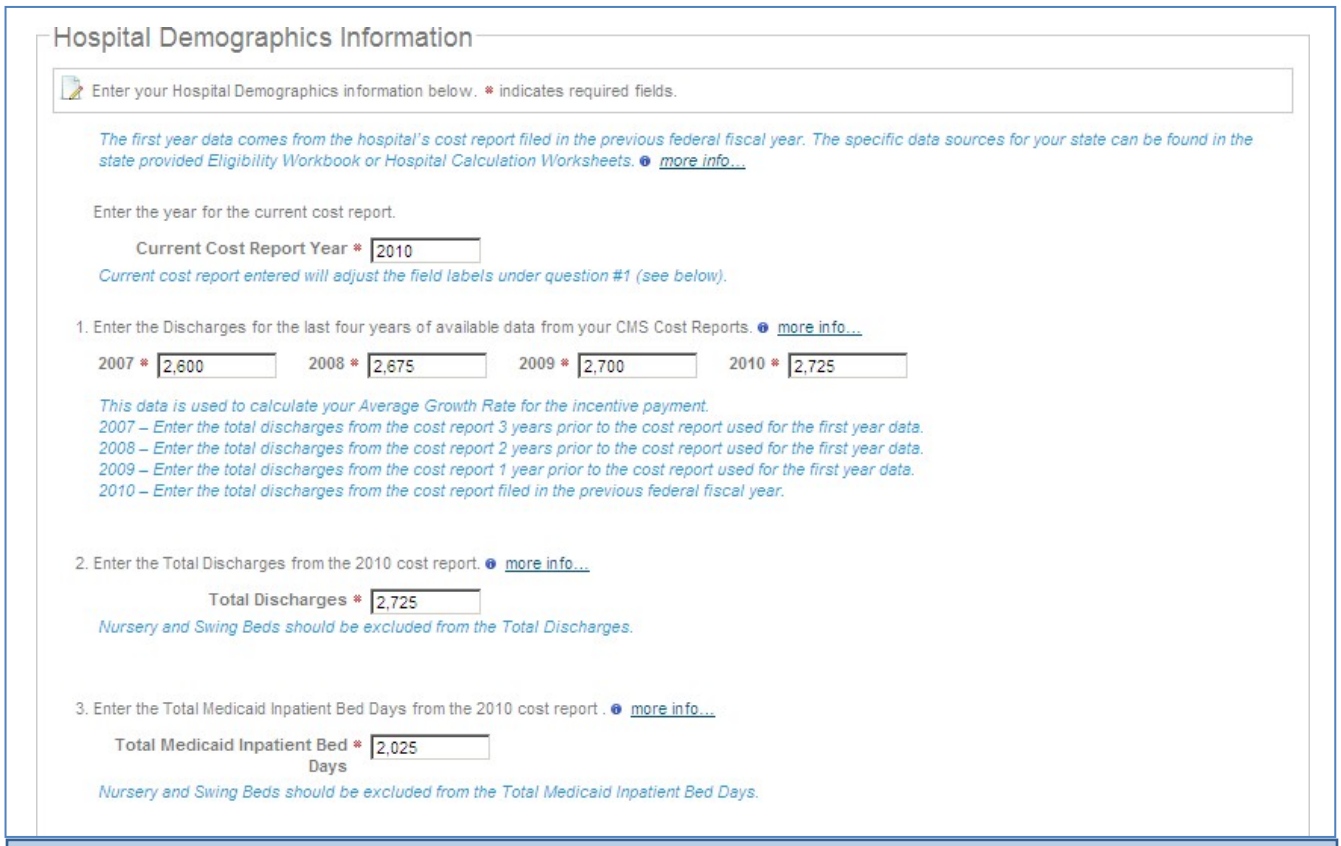
Step 2-Confirm Medicaid Eligibility-EH (cont.)



Medicaid Volume

- **Total Discharges for Representative period**-Enter the Total discharges over the selected representative period
- **Medicaid Discharges for Representative period**-Enter the Medicaid inpatient discharges and emergency room discharges over the selected representative period
- **Medicaid patients from another state**-Identify if the hospital has Medicaid patients outside the state of Alaska
- **Average Length of Stay**-Enter the average length of stay for the hospital fiscal year that ends in the prior federal fiscal year, the average length of stay calculation is calculated by the Total inpatient bed days divided by Total Discharges
- **Medicaid Volume Calculation**- Select the calculate button to determine if the hospital meets the minimum patient volume

Step 2-Confirm Medicaid Eligibility-EH (cont.)



Hospital Demographic Information

Current Cost Report Year-Enter the year from the hospital cost report that has ended in the previous federal fiscal year

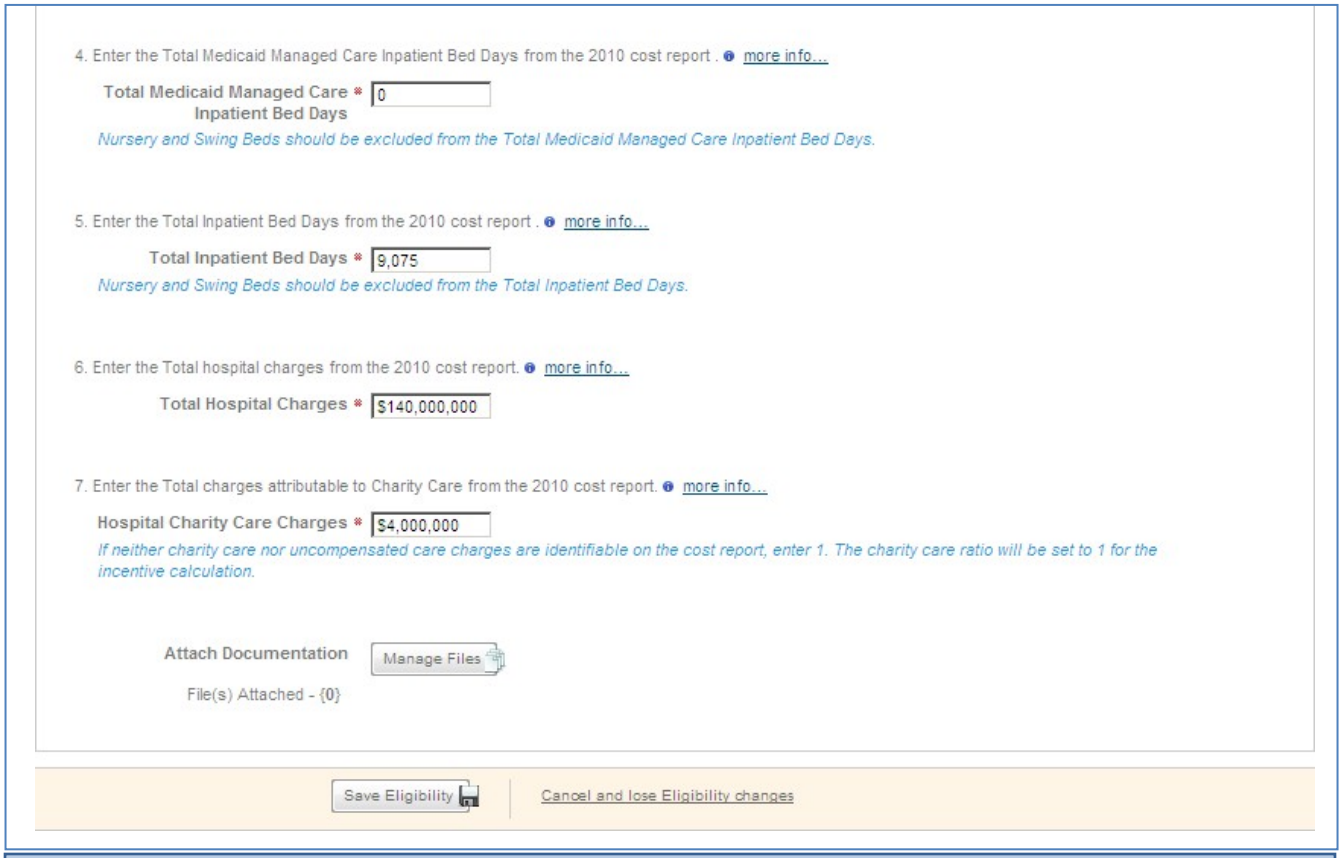
4 years of Discharge data-Enter the total discharges for the acute care portion of the hospital, this excludes nursery discharges, for the previous 4 most recent years of hospital cost report discharge data.

Total Discharges-Enter the total discharges for the acute care portion of the hospital from the hospital cost report ending in the federal fiscal prior to the payment year. The discharges also exclude nursery discharges. Note: Payments years are based on the federal fiscal year for hospitals.

Example: If a hospital is applying for an incentive payment in federal fiscal year 2011 (October 1, 2010-September 30, 2011), and the hospital fiscal year runs from July1-June 30, the hospital cost report data used would be collected from the hospital cost report ending on June 30, 2010.

Total Medicaid Inpatient Bed Days-Enter the total Medicaid Inpatient Bed days from the hospital cost report ending in the federal fiscal year prior to the payment year. The Medicaid inpatient bed days exclude nursery days. If a patient is dually eligible for both Medicare and Medicaid, if the Medicare inpatient bed days would count for the purposes of calculating the Medicare share they cannot be counted in the numerator for the Medicaid share.

Step 2-Confirm Medicaid Eligibility-EH (cont.)



Hospital Demographic Information

Medicaid Managed Care Inpatient Bed Days-The Alaska Medical Assistance Program does not have a Medicaid Managed Care program. Hospitals may enter "0" in this field in the SLR.

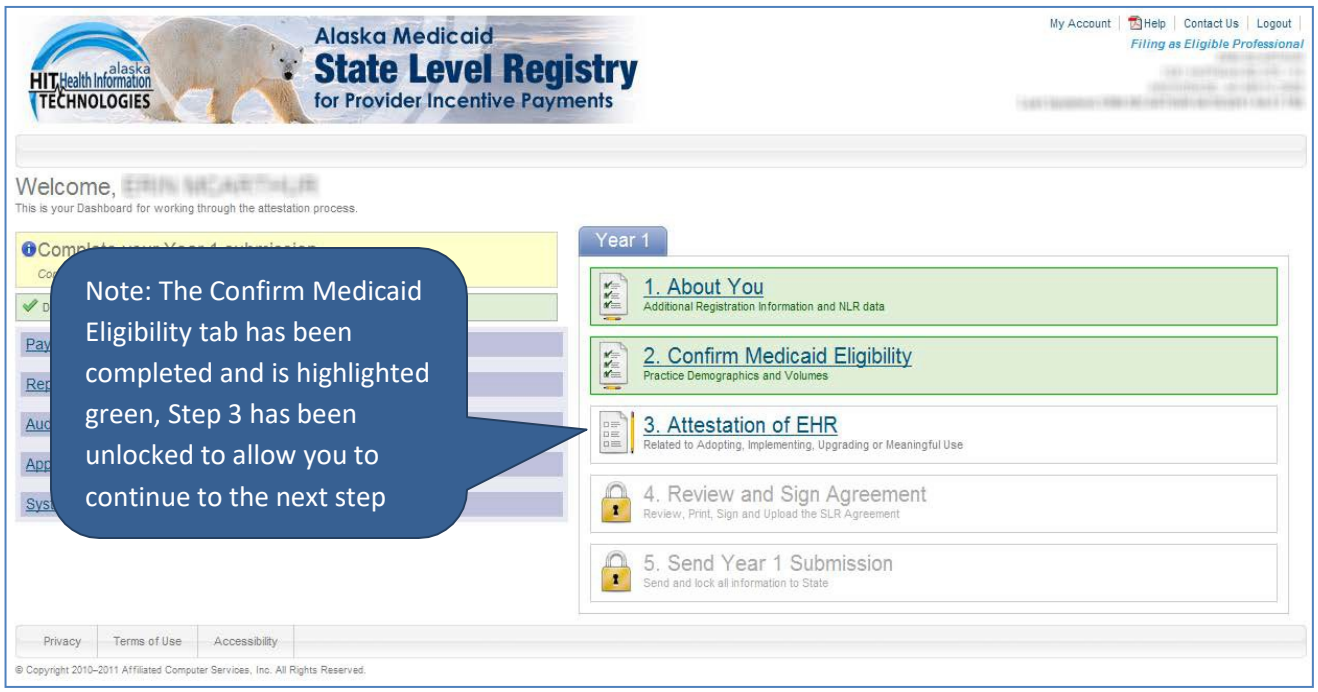
Total Inpatient Bed Day- Enter the total inpatient bed days for the acute care portion of the hospital from the hospital cost report ending in the federal fiscal prior to the payment year. The inpatient bed days excludes nursery days.

Total Hospital Charges-Enter the total hospital charges from the hospital cost report ending in the federal fiscal year prior to the payment year.

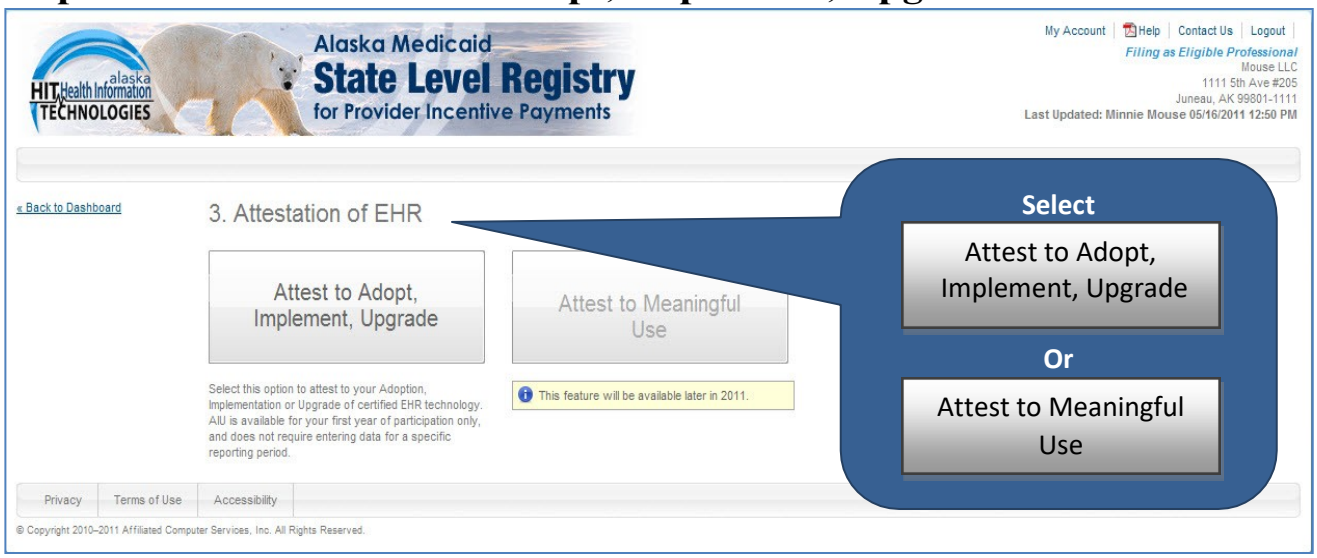
Hospital Charity Care Charges-Enter the total hospital charity care charges from the hospital cost report ending in the federal fiscal year prior to the payment year.

Save Eligibility-Once all of the information has been entered select save eligibility and you will be taken to the next screen Step 3. Attestation of EHR

SLR Home page-Confirm Medicaid Eligibility-Complete



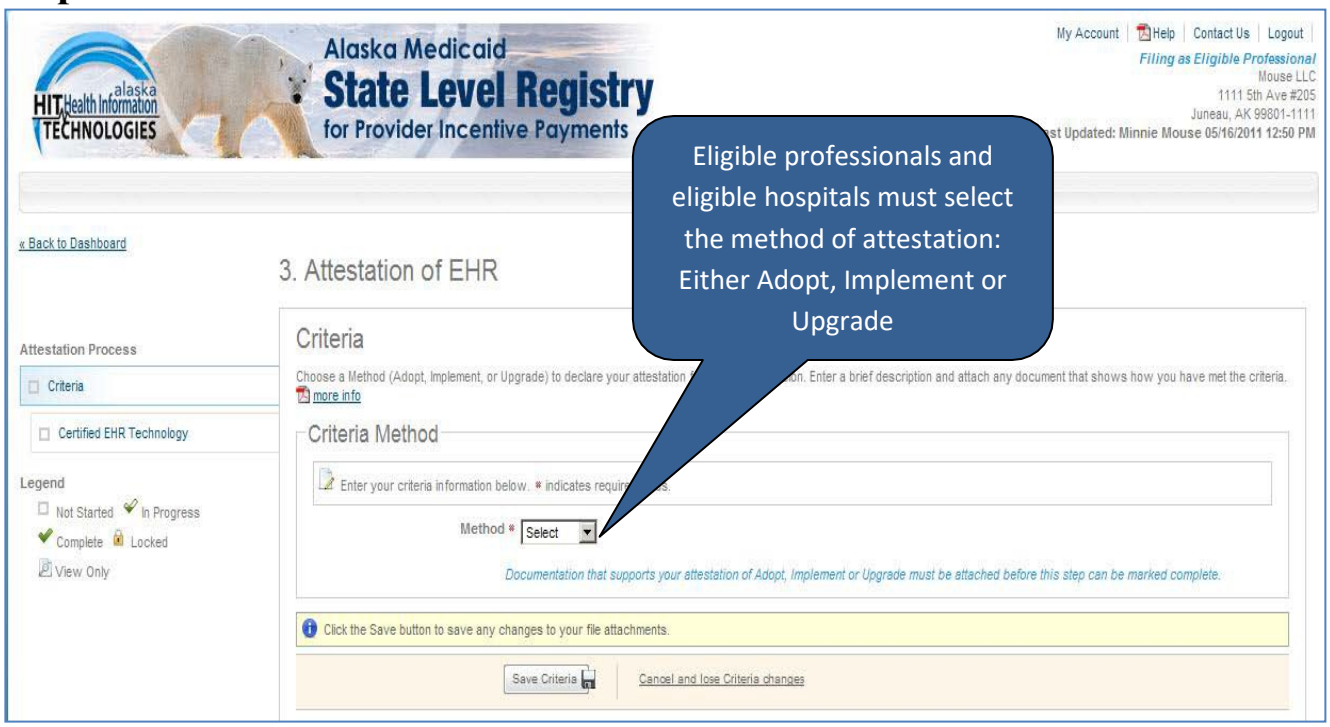
Step 3-Attestation of EHR-Adopt, Implement, Upgrade



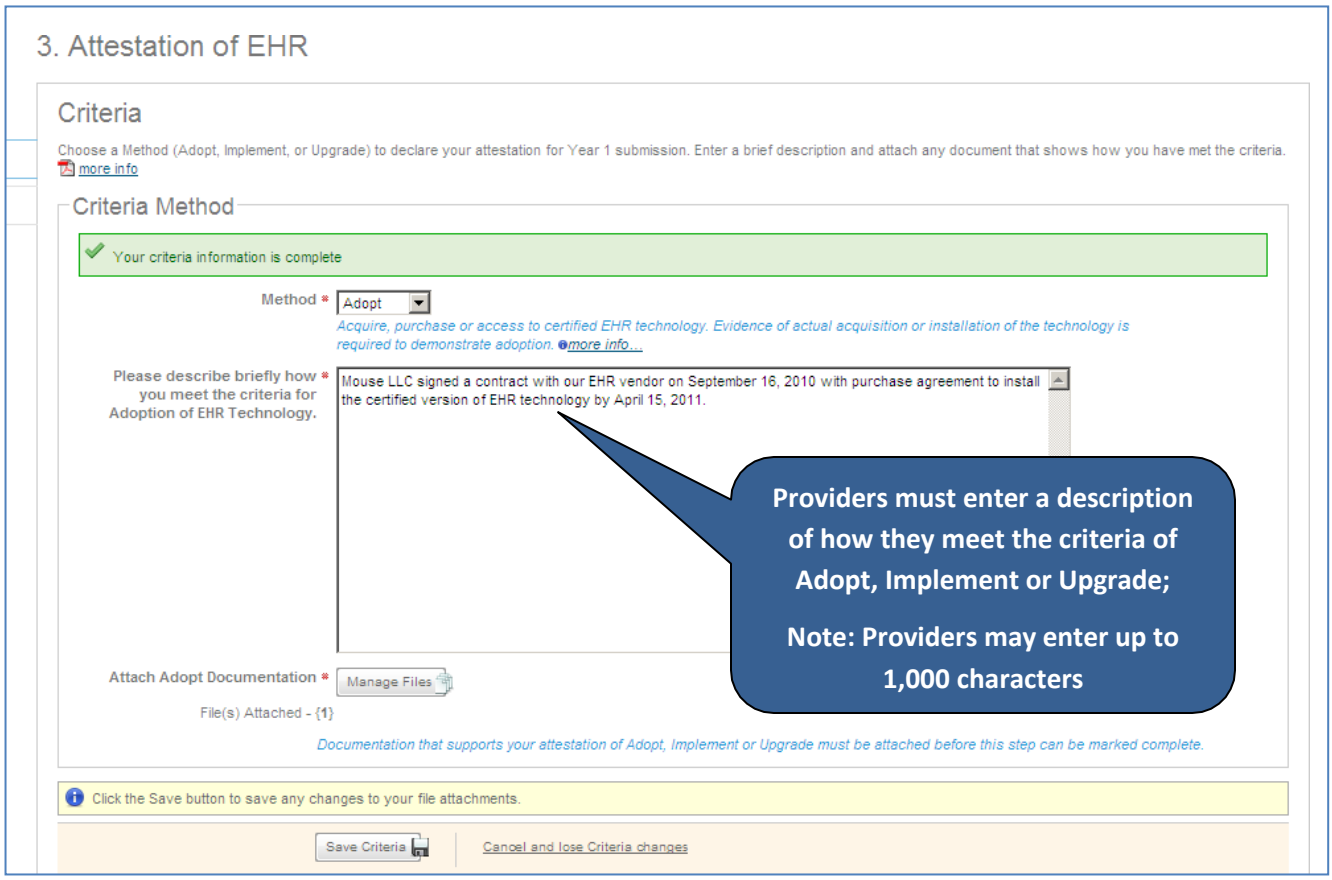
Attestation of EHR- In the first year of participation in the Medicaid EHR Incentive Program eligible professionals and eligible hospitals have the option to attest to Adopt, Implement or Upgrade to a certified EHR Technology or to meaningful use. In the second year of participation they may attest to meaningful use.

Note: The attestation of meaningful use will be available for the Alaska Medicaid EHR Incentive Program in the beginning of 2012.

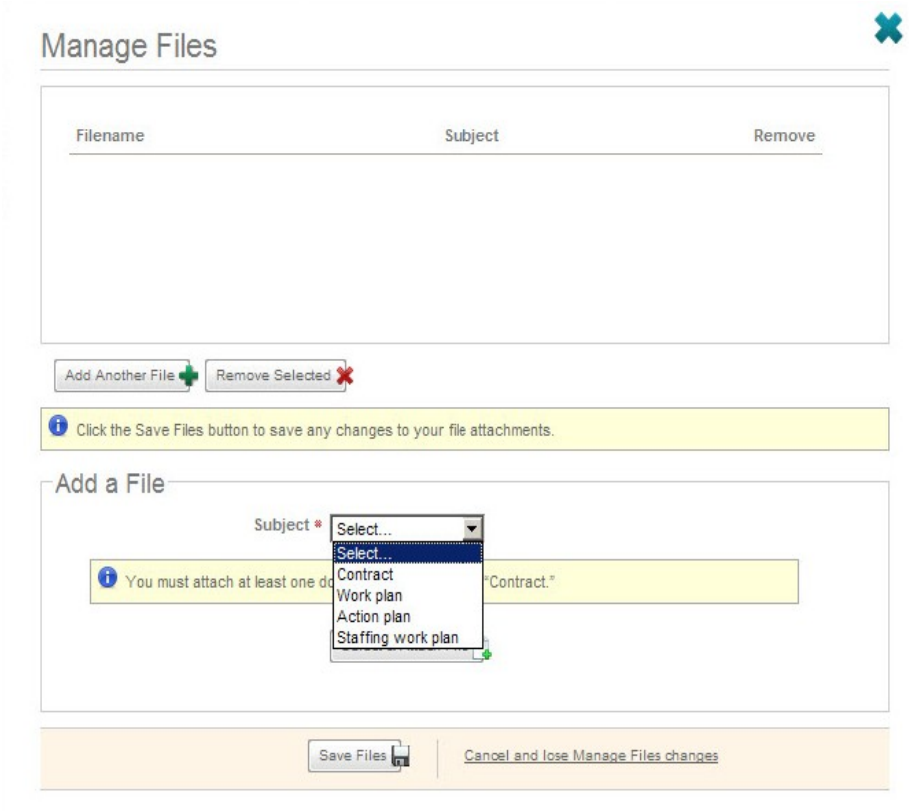
Step 3-Attestation of EHR-AIU Method



Step 3-Attestation of EHR-AIU Method (cont.)



Step 3-Attestation of EHR-AIU Method-Attach Document (cont.)

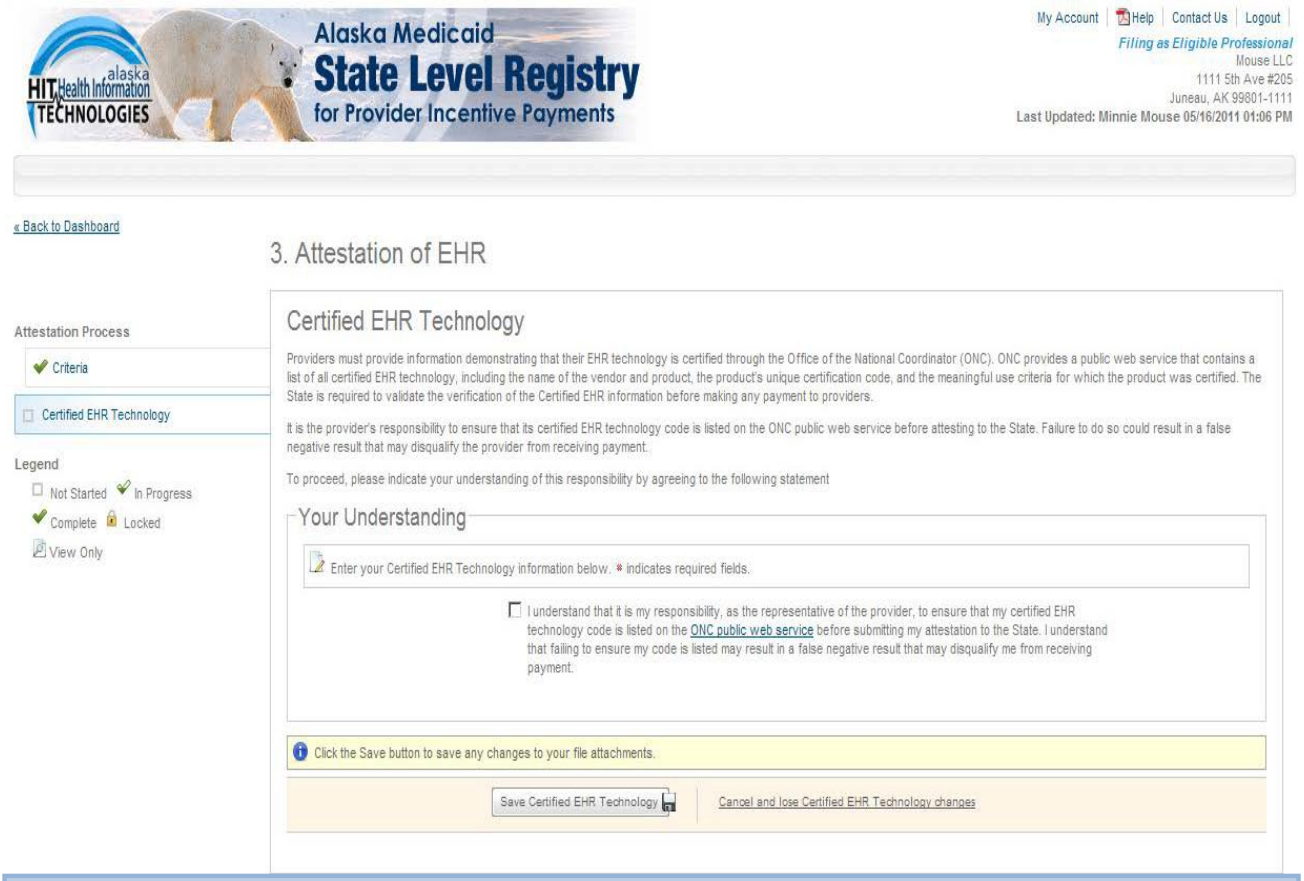


Manage Files

Providers must upload a file that supports the criteria for Adopt, Implement or Upgrade. At a minimum, providers are required to upload a document with a subject of "Contract" in order to complete the SLR attestation process. Other acceptable documents could include a work plan, action plan or staffing work plan.

Note: A letter of agreement that has been signed by both the provider/group and the EHR vendor is an acceptable document to upload under "Contract"

Step 3-Attestation of EHR-EHR Certification

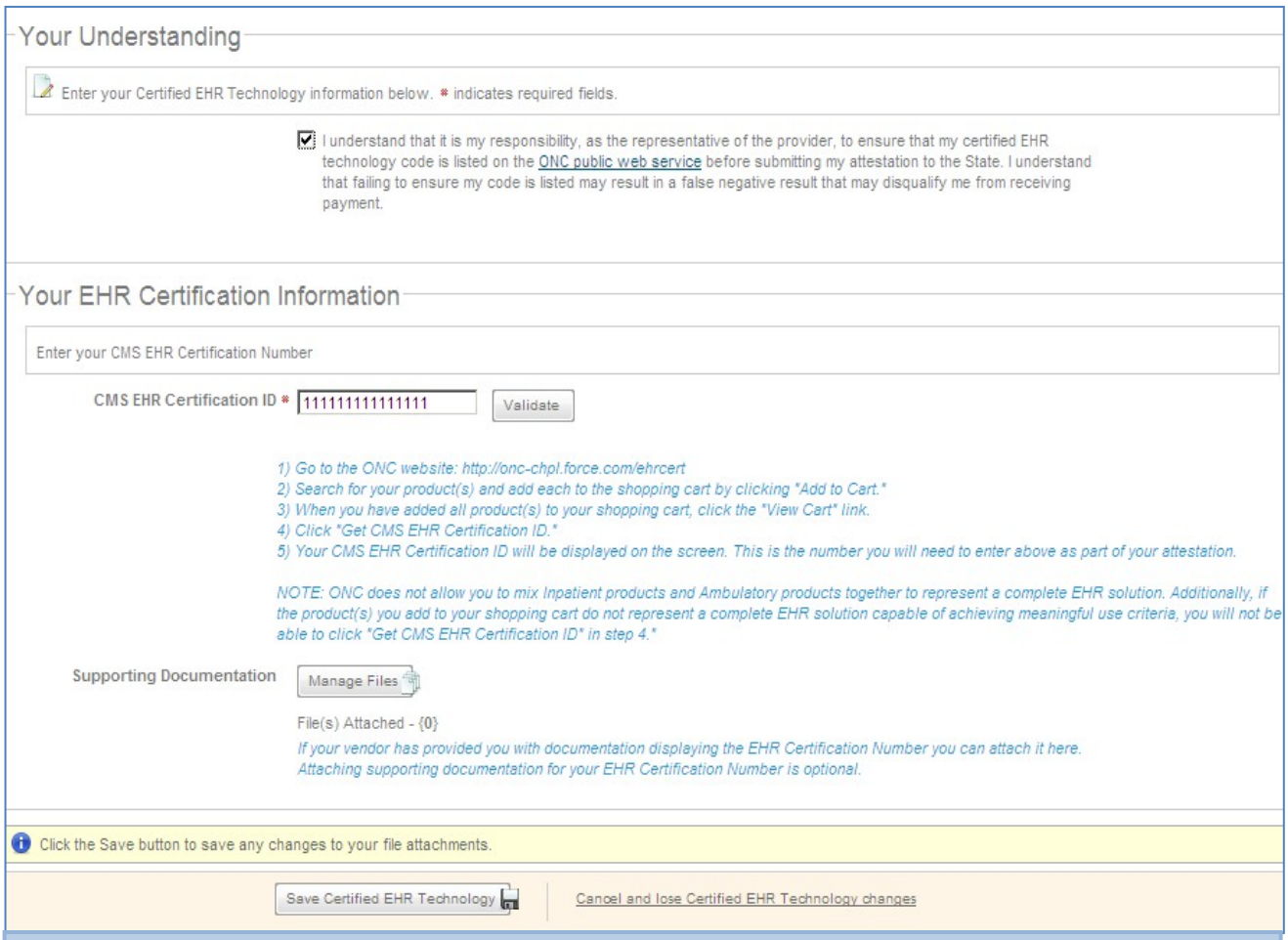


Your Understanding-The provider or representative of the provider must agree to the following statement:

☑ I understand that it is my responsibility, as the representative of the provider, to ensure that my certified EHR technology code is listed on the ONC public web service before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment.

Once you agree with the "Your Understanding" statement, additional steps will appear where you will be required to enter the EHR Certification Information

Step 3-Attestation of EHR - EHR Certification (cont.)



CMS EHR Certification ID-You must enter the CMS EHR Certification ID

1) Go to the ONC website: http://onc-chpl.force.com/ehrcert
2) Search for your product(s) and add each to the shopping cart by clicking "Add to Cart."
3) When you have added all product(s) to your shopping cart, click the "View Cart" link.
4) Click "Get CMS EHR Certification ID."
5) Your CMS EHR Certification ID will be displayed on the screen. This is the number you will need to enter above as part of your attestation.

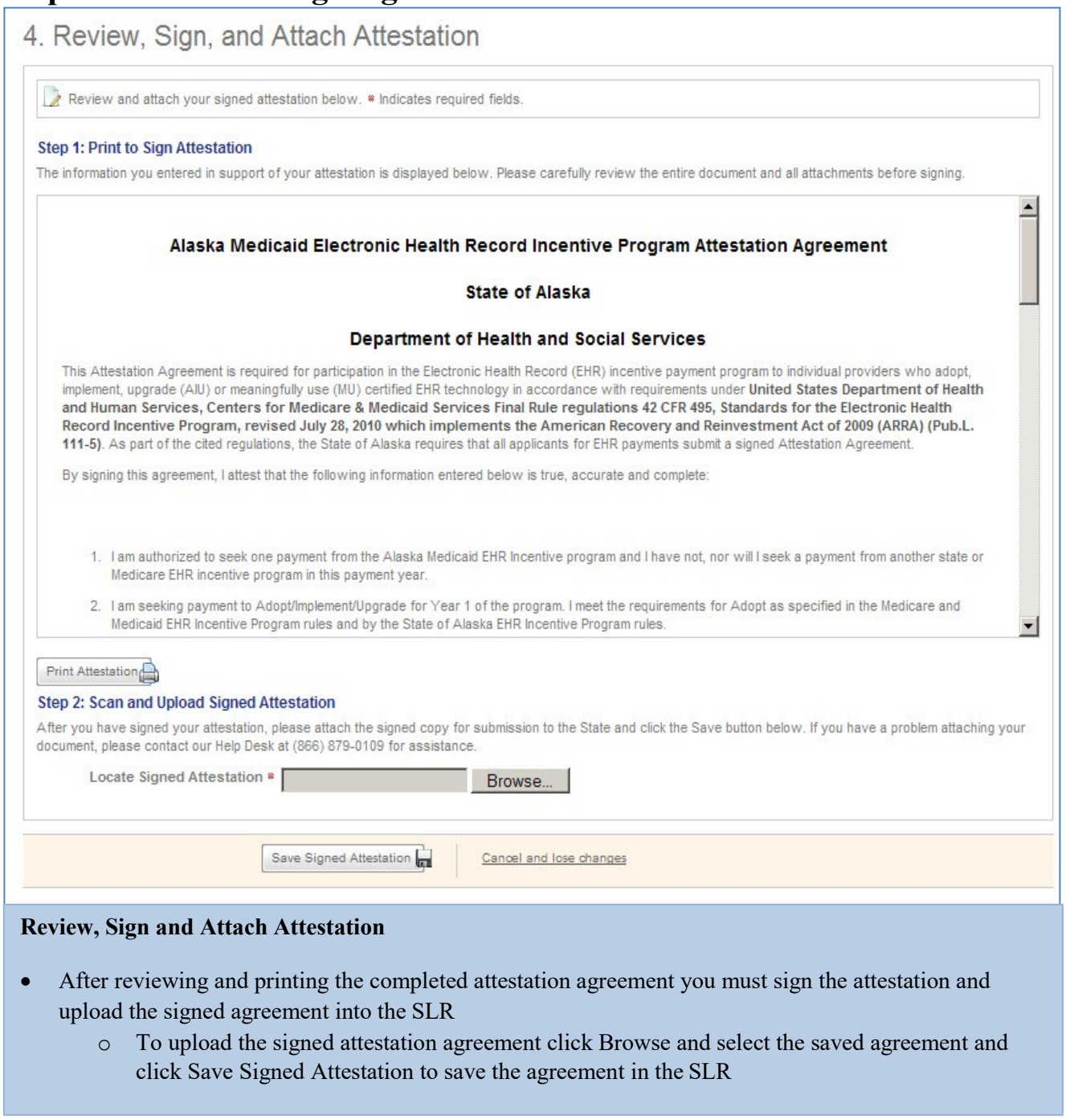
Ex. Your CMS EHR Certification ID is: A014E01IF3HLEAZ

Note: ONC does not allow you to mix Inpatient products and Ambulatory products together to represent a complete EHR solution. Additionally, if the product(s) you add to your shopping cart do not represent a complete EHR solution capable of achieving meaningful use criteria, you will not be able to click "Get CMS EHR Certification ID" in step 4."

Supporting Documentation: Proof of the version of the EHR you have identified as your CEHRT. If your CEHRT is for Allscripts V11.4.1, please provide proof that you are using this version. This could be a vendor letter or an invoice with the version listed on it. If you any questions about your documentation to attach, please ask us.

SLR Home page-Attestation of EHR-Complete

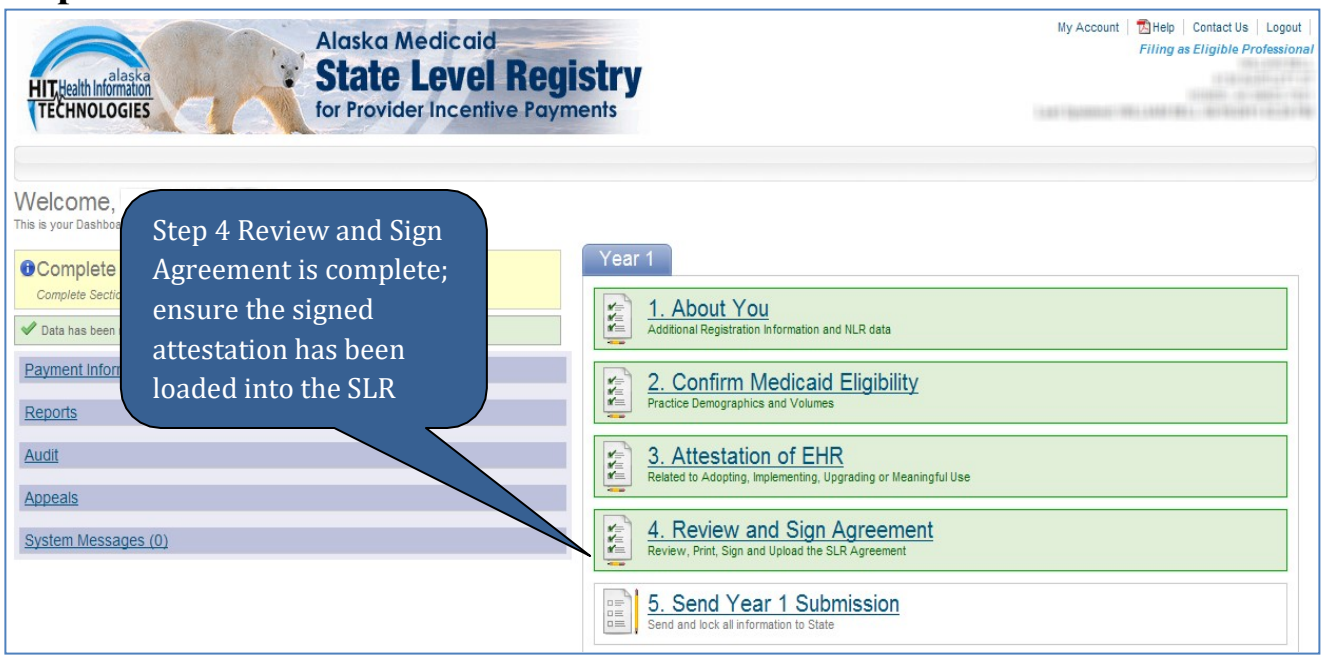
Step 4-Review and Sign Agreement



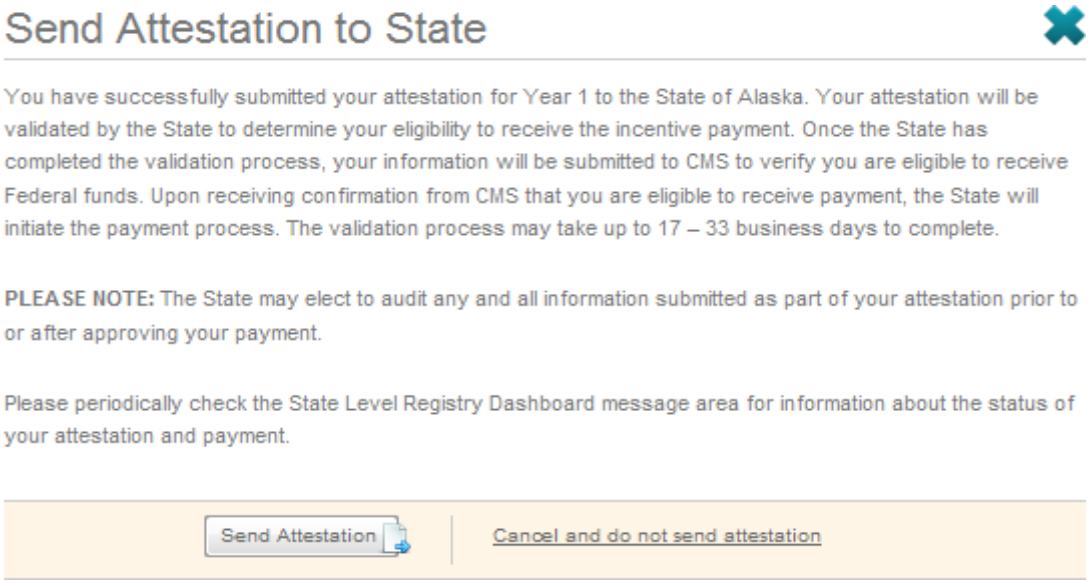
Review, Sign and Attach Attestation

- After reviewing and printing the completed attestation agreement you must sign the attestation and upload the signed agreement into the SLR
    - To upload the signed attestation agreement click Browse and select the saved agreement and click Save Signed Attestation to save the agreement in the SLR

Step 5-Send Year 1 Submission



Send Attestation



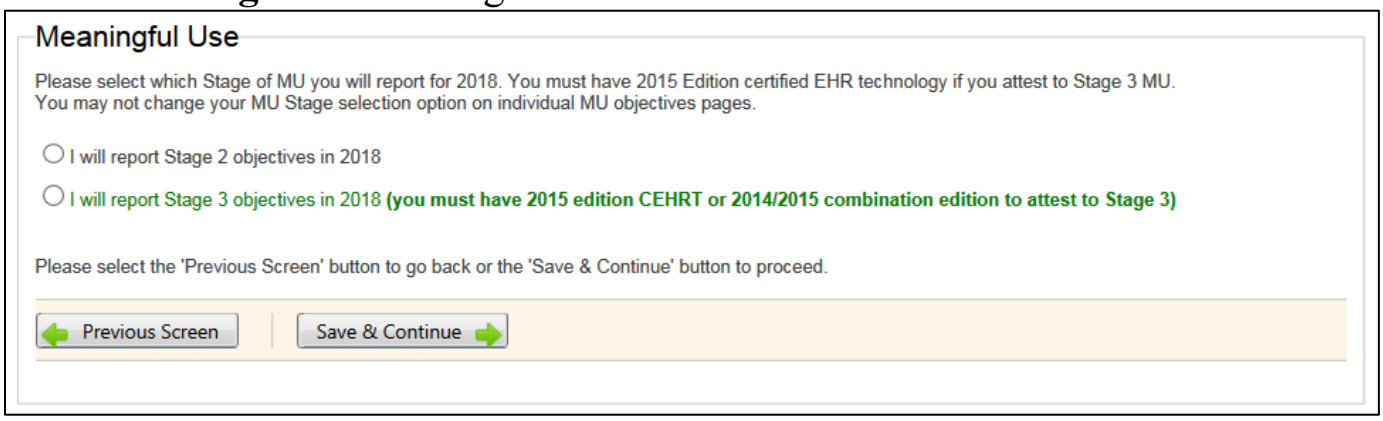
Send Year 1 Submission

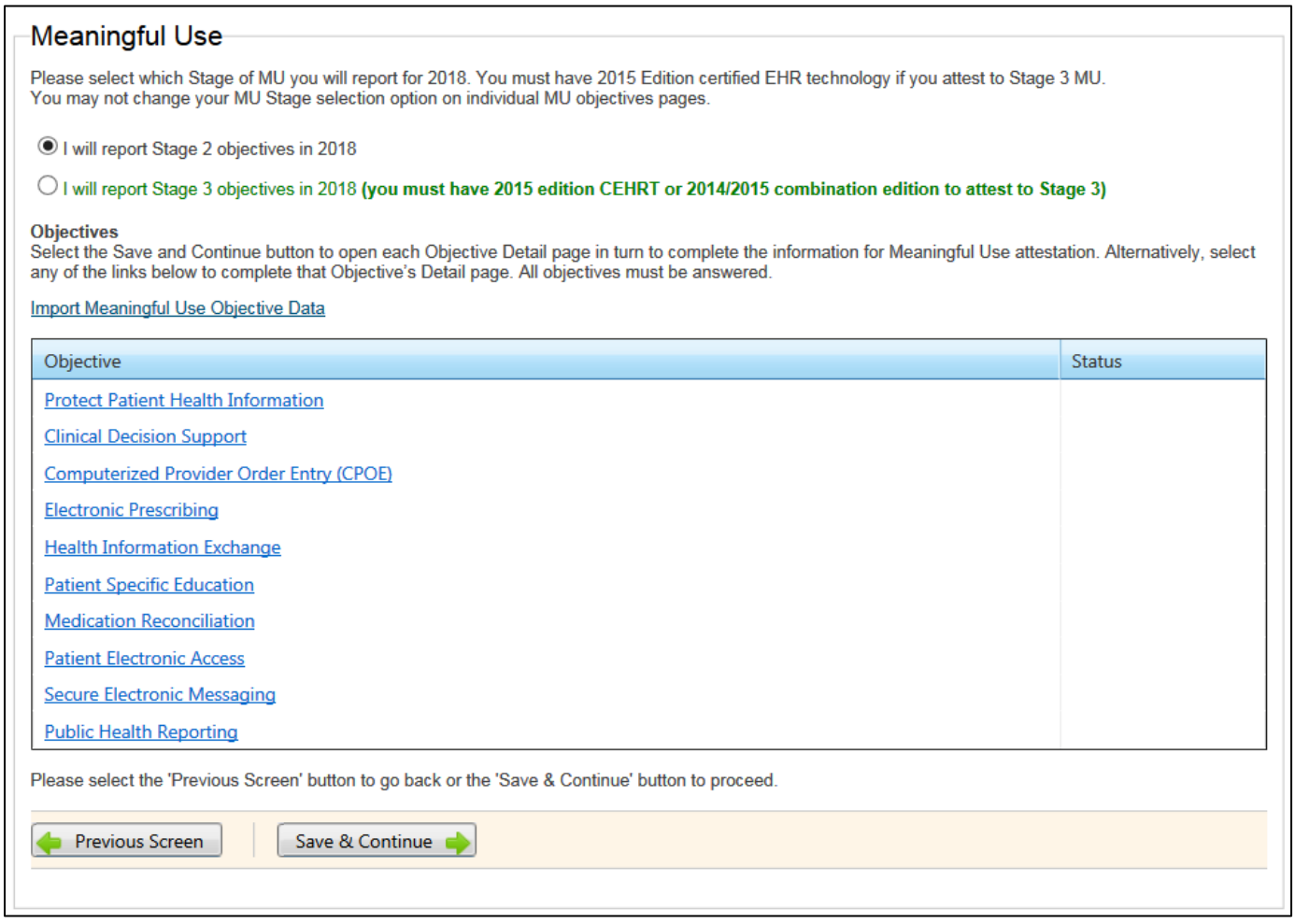
Sent Attestation Confirmation – Once your attestation has been send, the SLR will provide a message that confirms that the attestation has been submitted

Year 1 Attestation Complete

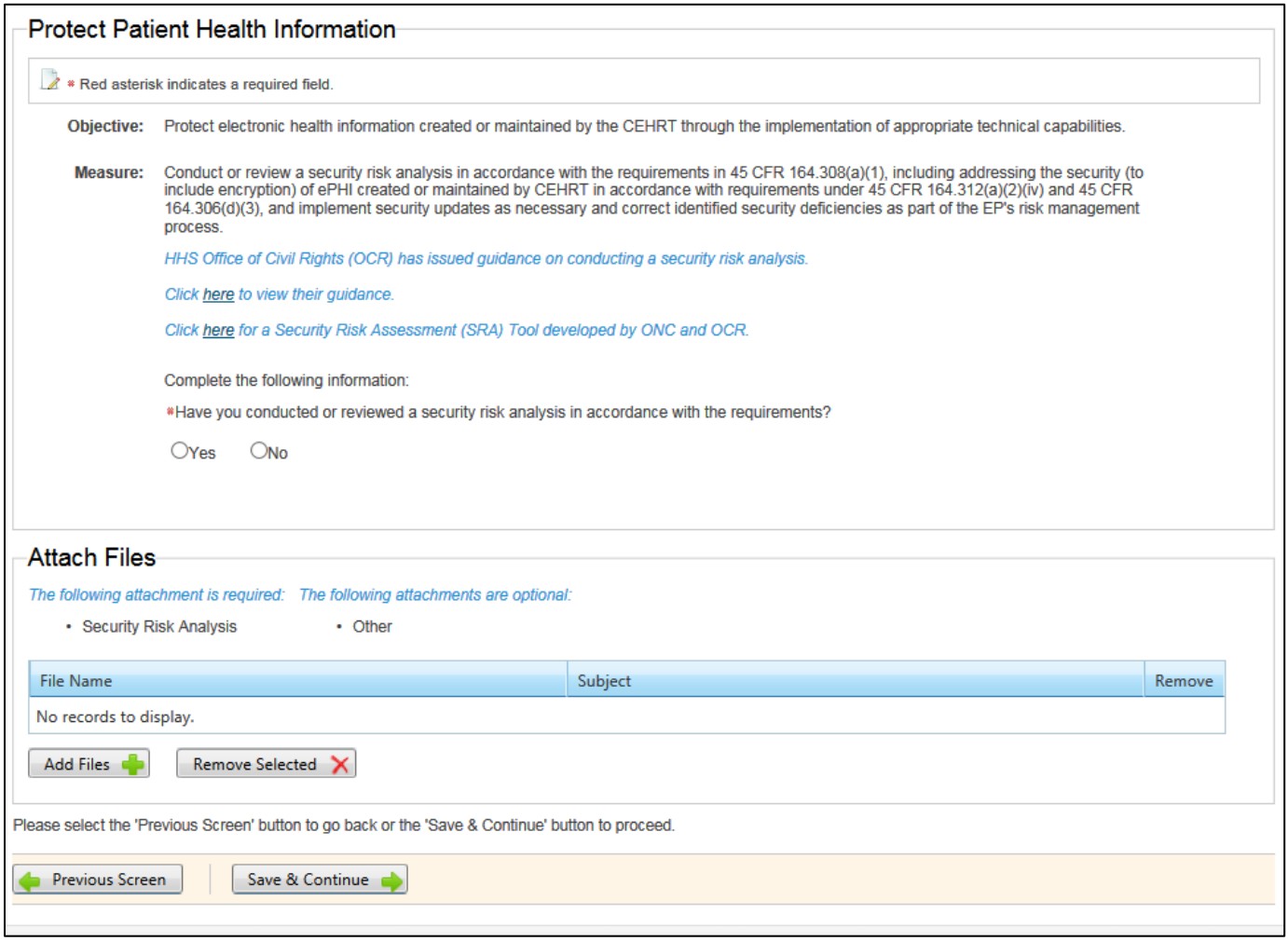
Alaska State Registry Screenshots – Program Year 2018

Modified Stage 2 – Meaningful Use Measures





Protect Patient Health Information



Protect Patient Health Information

* Red asterisk indicates a required field.

Objective: Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process.

HHS Office of Civil Rights (OCR) has issued guidance on conducting a security risk analysis.

Click here to view their guidance.

Click here for a Security Risk Assessment (SRA) Tool developed by ONC and OCR.

Complete the following information:

*Have you conducted or reviewed a security risk analysis in accordance with the requirements?

(•) Yes ( ) No

* **Date within the current Program Year the security risk analysis was completed**

Please enter the date your security risk analysis was completed.

Attach Files

The following attachment is required:

- Security Risk Analysis

The following attachments are optional:

- Other

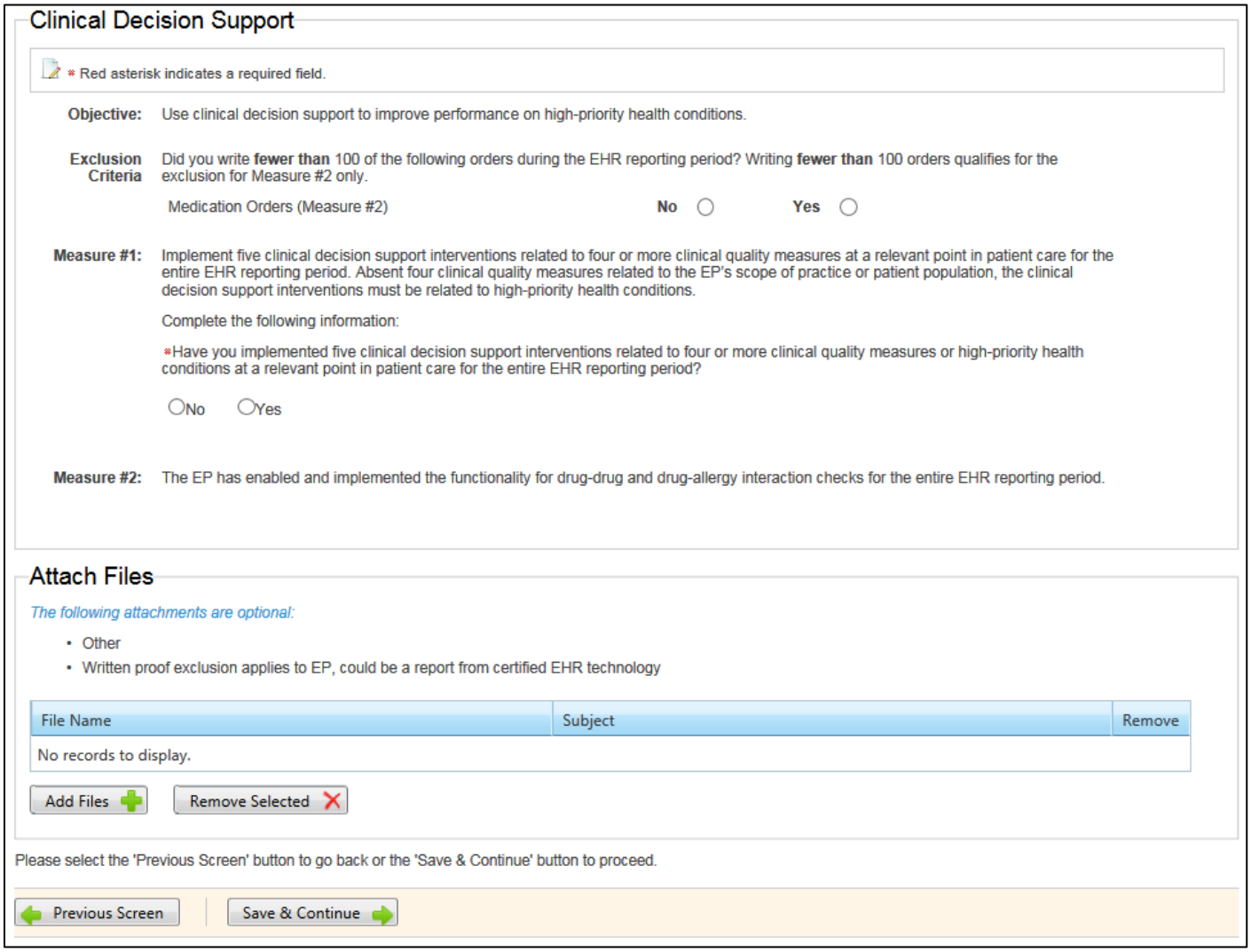
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

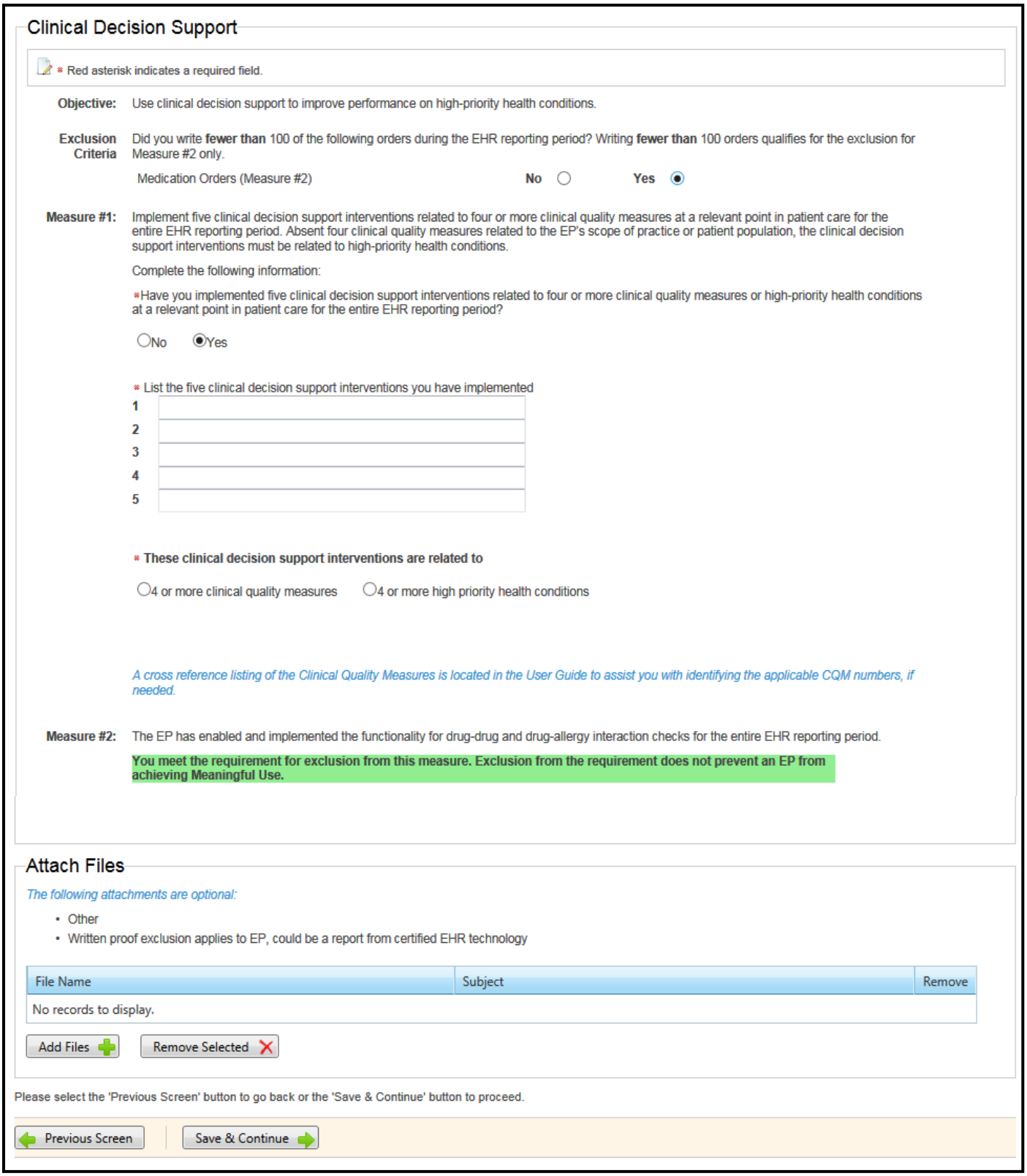
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Clinical Decision Support



Exclusion for Measure #2



Clinical Decision Support

* Red asterisk indicates a required field.

Objective: Use clinical decision support to improve performance on high-priority health conditions.

Exclusion Criteria Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for Measure #2 only.

Medication Orders (Measure #2) **No** ○ **Yes** ◉

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

○No ◉Yes

* List the five clinical decision support interventions you have implemented

1
2
3
4
5

* **These clinical decision support interventions are related to**

○4 or more clinical quality measures ○4 or more high priority health conditions

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Attach Files

The following attachments are optional:

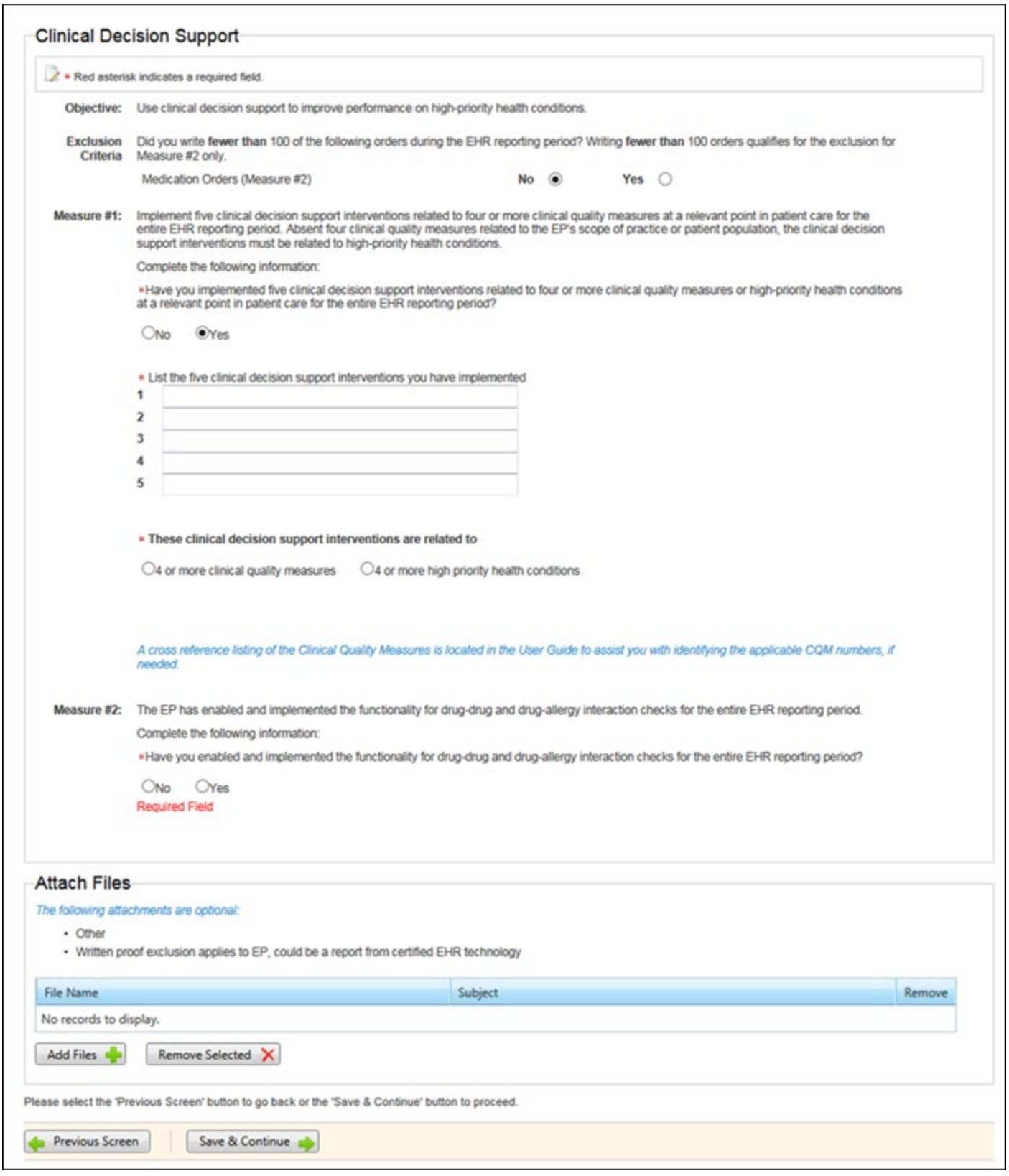
- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen Save & Continue



Clinical Decision Support

* Red asterisk indicates a required field.

Objective: Use clinical decision support to improve performance on high-priority health conditions.

Exclusion Criteria Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for Measure #2 only.

Medication Orders (Measure #2) **No** ◉ **Yes** ○

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

○No ◉Yes

* List the five clinical decision support interventions you have implemented

1
2
3
4
5

* **These clinical decision support interventions are related to**

○4 or more clinical quality measures ○4 or more high priority health conditions

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Complete the following information:

*Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

○No ○Yes

Required Field

Attach Files

The following attachments are optional:

- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

4 or more Clinical Quality Measures

Clinical Decision Support

* Red asterisk indicates a required field.

Objective: Use clinical decision support to improve performance on high-priority health conditions.

Exclusion Criteria Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for Measure #2 only.

Medication Orders (Measure #2) **No** ◉ **Yes** ○

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

○No ◉Yes

* List the five clinical decision support interventions you have implemented

1
2
3
4
5

* **These clinical decision support interventions are related to**

◉4 or more clinical quality measures ○4 or more high priority health conditions

* **Select CQMs**

CMS50
CMS66
CMS75
CMS133

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Complete the following information:

*Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

○No ○Yes

Required Field

Attach Files

The following attachments are optional:

- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

4 or more High Priority Health Conditions

Clinical Decision Support

* Red asterisk indicates a required field.

Objective: Use clinical decision support to improve performance on high-priority health conditions.

Exclusion Criteria Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for Measure #2 only.

Medication Orders (Measure #2) **No** ◉ **Yes** ○

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

○No ◉Yes

* List the five clinical decision support interventions you have implemented

1
2
3
4
5

* **These clinical decision support interventions are related to**

○4 or more clinical quality measures ◉4 or more high priority health conditions

*
1
2
3
4

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Complete the following information:

*Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

○No ○Yes

Required Field

Attach Files

The following attachments are optional:

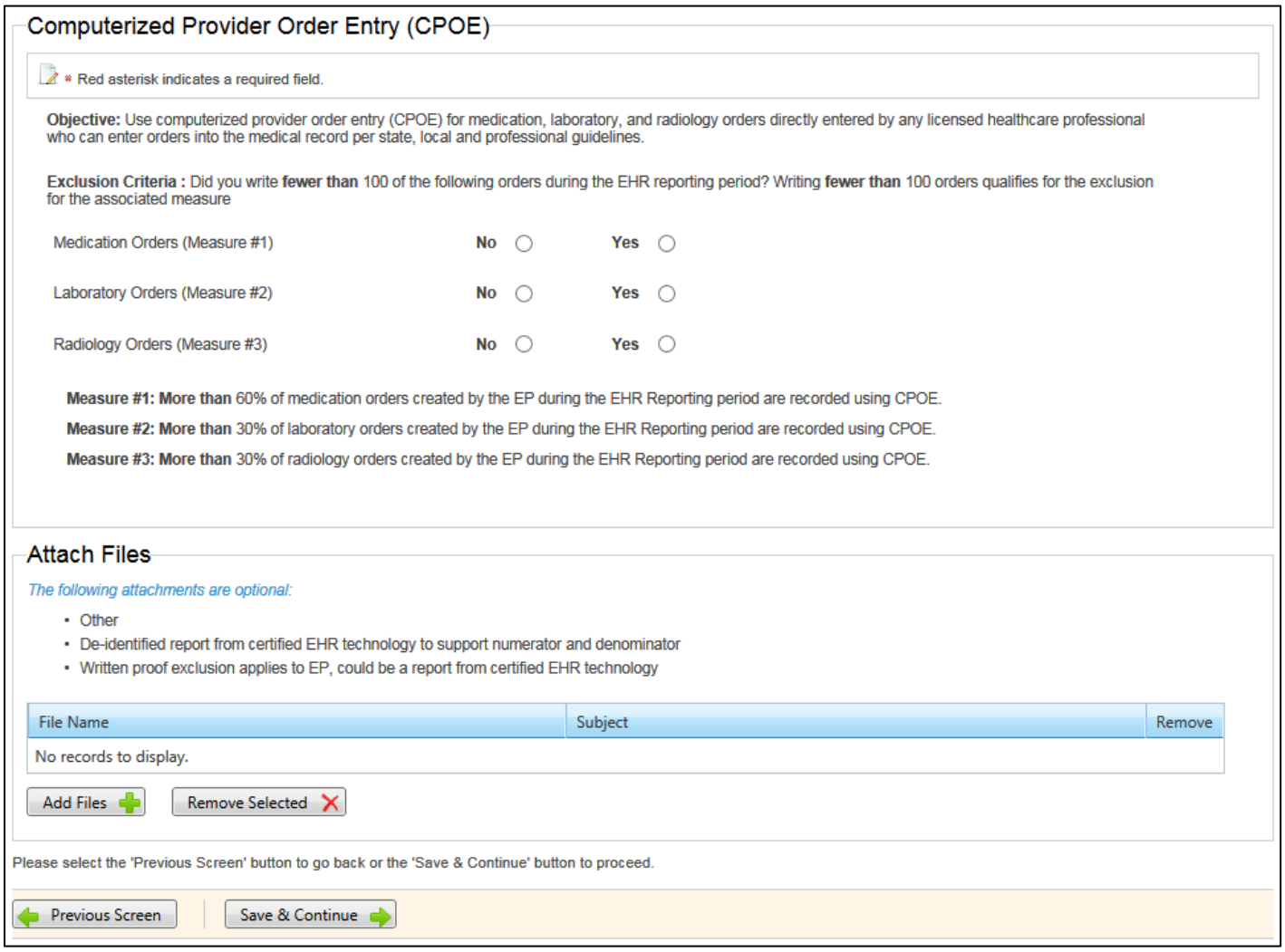
- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue



Computerized Provider Order Entry (CPOE)

* Red asterisk indicates a required field.

Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Exclusion Criteria : Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for the associated measure

Medication Orders (Measure #1)	**No** ○	**Yes** ○
Laboratory Orders (Measure #2)	**No** ○	**Yes** ○
Radiology Orders (Measure #3)	**No** ○	**Yes** ○

Measure #1: More than 60% of medication orders created by the EP during the EHR Reporting period are recorded using CPOE.

Measure #2: More than 30% of laboratory orders created by the EP during the EHR Reporting period are recorded using CPOE.

Measure #3: More than 30% of radiology orders created by the EP during the EHR Reporting period are recorded using CPOE.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

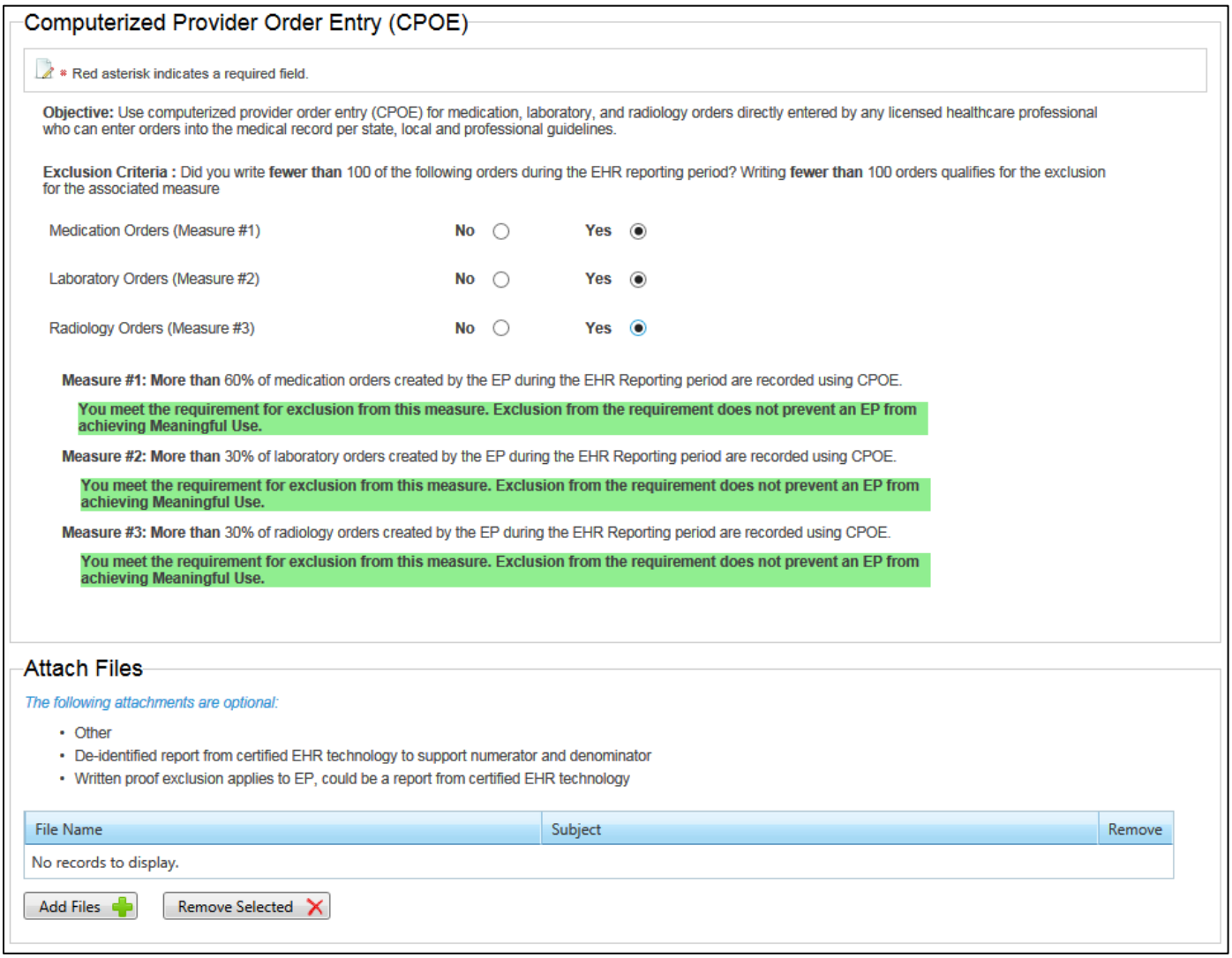
File Name	Subject	Remove
No records to display.		

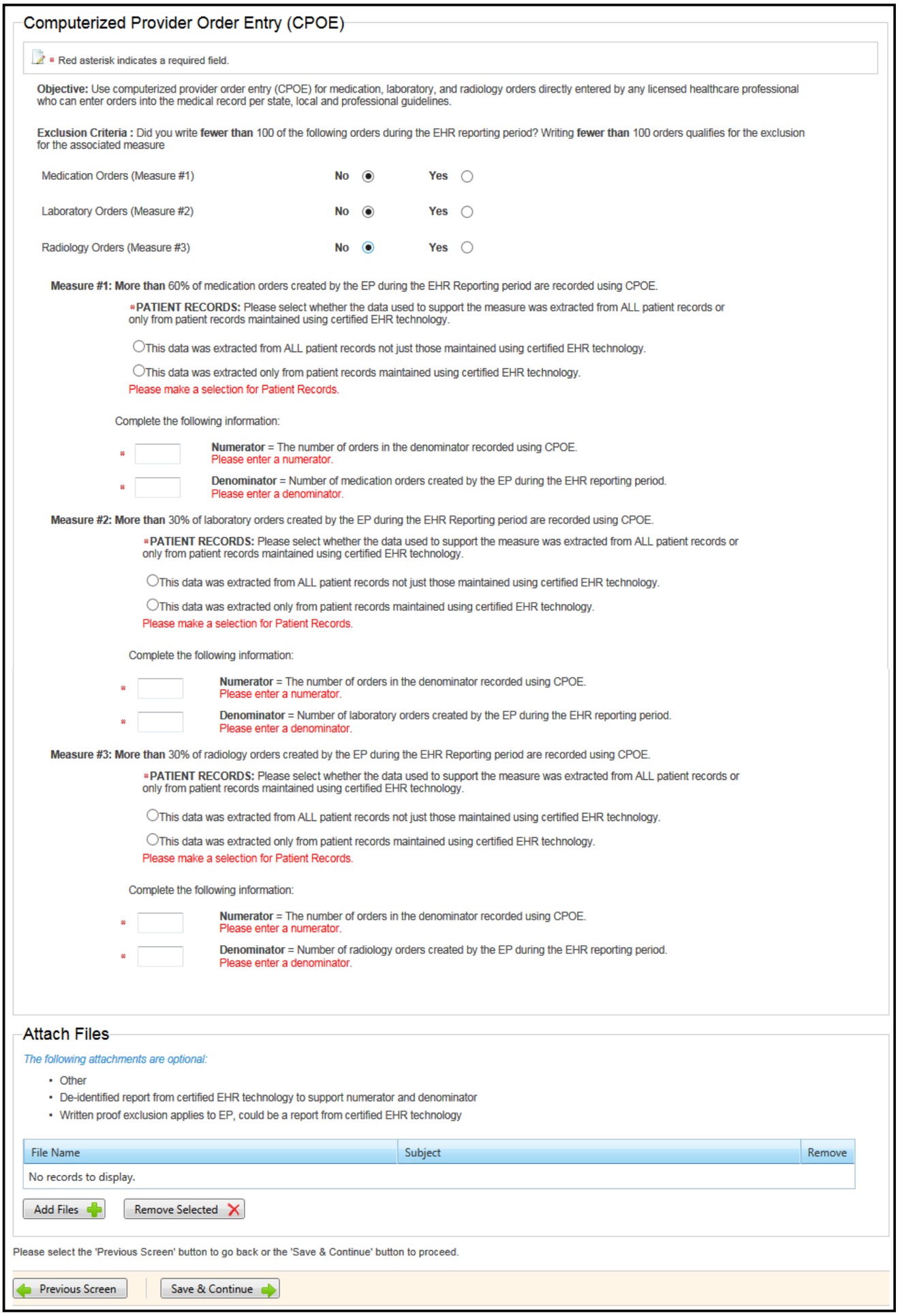
Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Exclusions


Computerized Provider Order Entry (CPOE)
* Red asterisk indicates a required field.
Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
Exclusion Criteria : Did you write fewer than 100 of the following orders during the EHR reporting period? Writing fewer than 100 orders qualifies for the exclusion for the associated measure
Medication Orders (Measure #1) No Yes
Laboratory Orders (Measure #2) No Yes
Radiology Orders (Measure #3) No Yes
Measure #1: More than 60% of medication orders created by the EP during the EHR Reporting period are recorded using CPOE.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Measure #2: More than 30% of laboratory orders created by the EP during the EHR Reporting period are recorded using CPOE.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Measure #3: More than 30% of radiology orders created by the EP during the EHR Reporting period are recorded using CPOE.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Attach Files
The following attachments are optional:
Other
De-identified report from certified EHR technology to support numerator and denominator
Written proof exclusion applies to EP, could be a report from certified EHR technology
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected



Computerized Provider Order Entry (CPOE)

* Red asterisk indicates a required field.

Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Exclusion Criteria : Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for the associated measure

Medication Orders (Measure #1)	**No** ◉	**Yes** ○
Laboratory Orders (Measure #2)	**No** ◉	**Yes** ○
Radiology Orders (Measure #3)	**No** ◉	**Yes** ○

Measure #1: More than 60% of medication orders created by the EP during the EHR Reporting period are recorded using CPOE.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

○ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

○ This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

* [ ] **Numerator** = The number of orders in the denominator recorded using CPOE.
Please enter a numerator.

* [ ] **Denominator** = Number of medication orders created by the EP during the EHR reporting period.
Please enter a denominator.

Measure #2: More than 30% of laboratory orders created by the EP during the EHR Reporting period are recorded using CPOE.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

○ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

○ This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

* [ ] **Numerator** = The number of orders in the denominator recorded using CPOE.
Please enter a numerator.

* [ ] **Denominator** = Number of laboratory orders created by the EP during the EHR reporting period.
Please enter a denominator.

Measure #3: More than 30% of radiology orders created by the EP during the EHR Reporting period are recorded using CPOE.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

○ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

○ This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

* [ ] **Numerator** = The number of orders in the denominator recorded using CPOE.
Please enter a numerator.

* [ ] **Denominator** = Number of radiology orders created by the EP during the EHR reporting period.
Please enter a denominator.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

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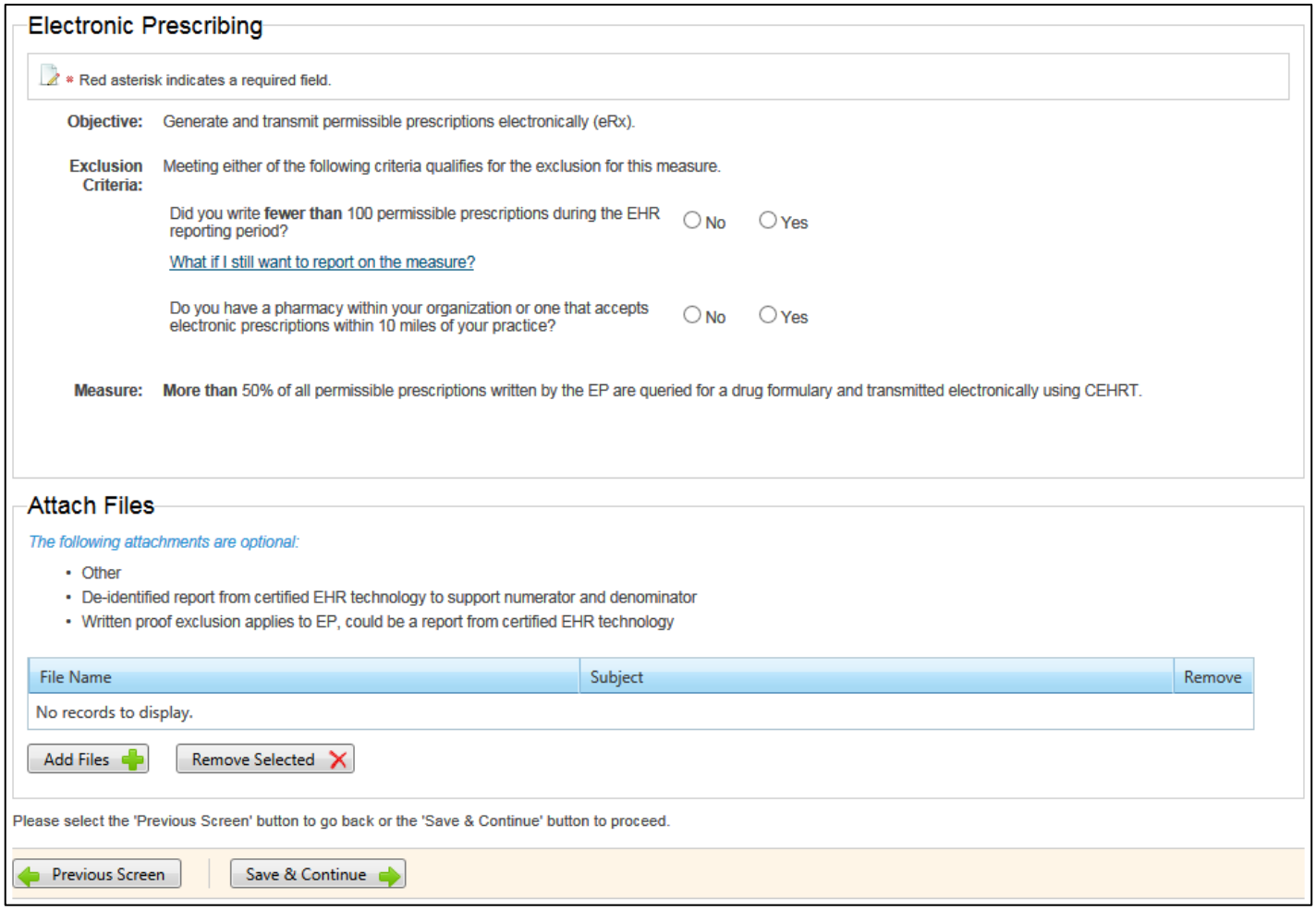
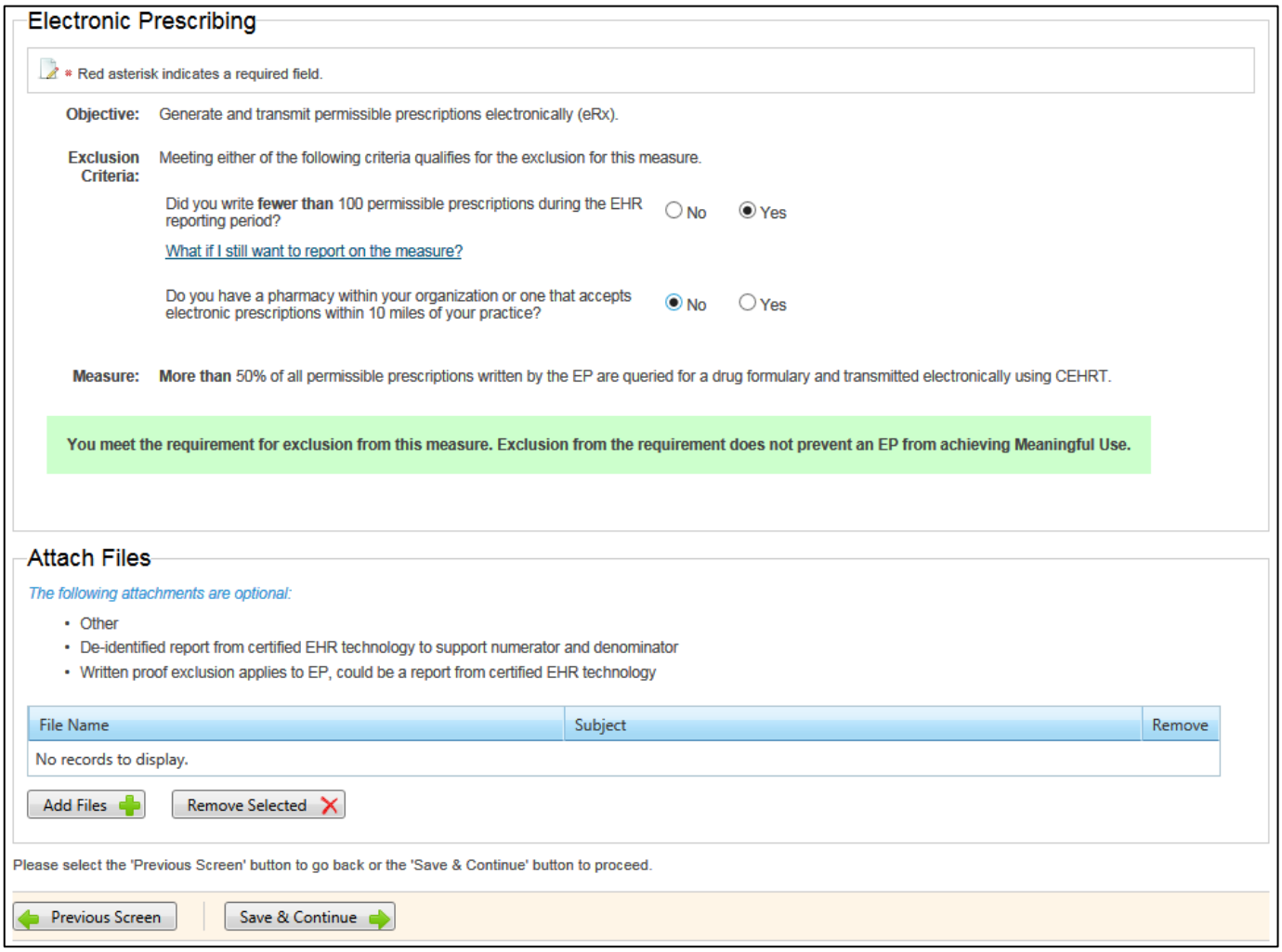
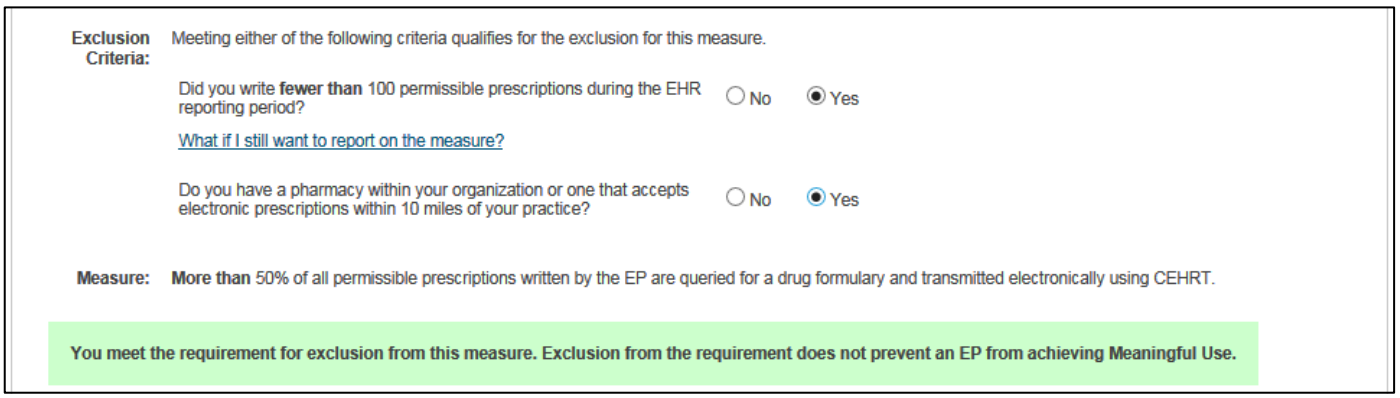
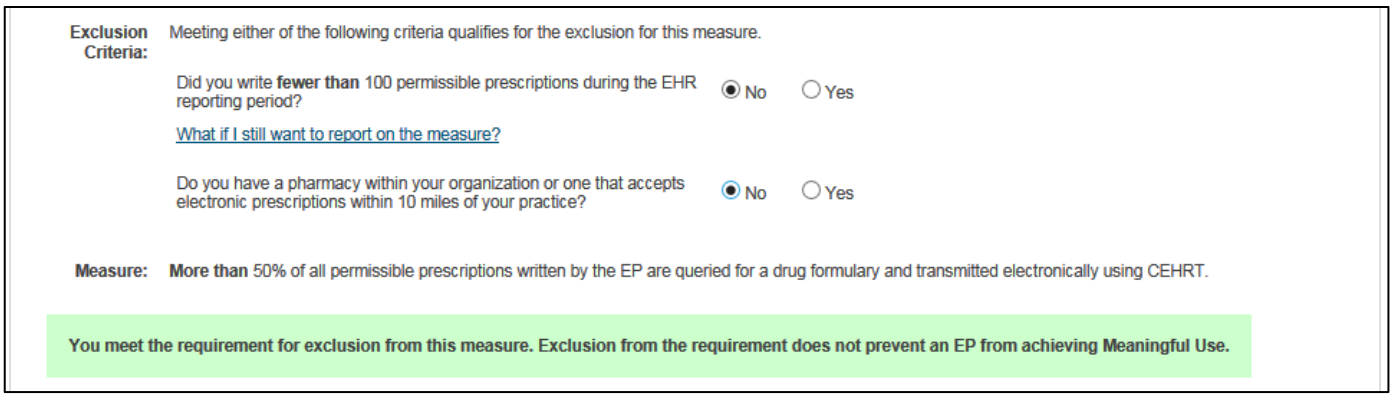
Electronic Prescribing



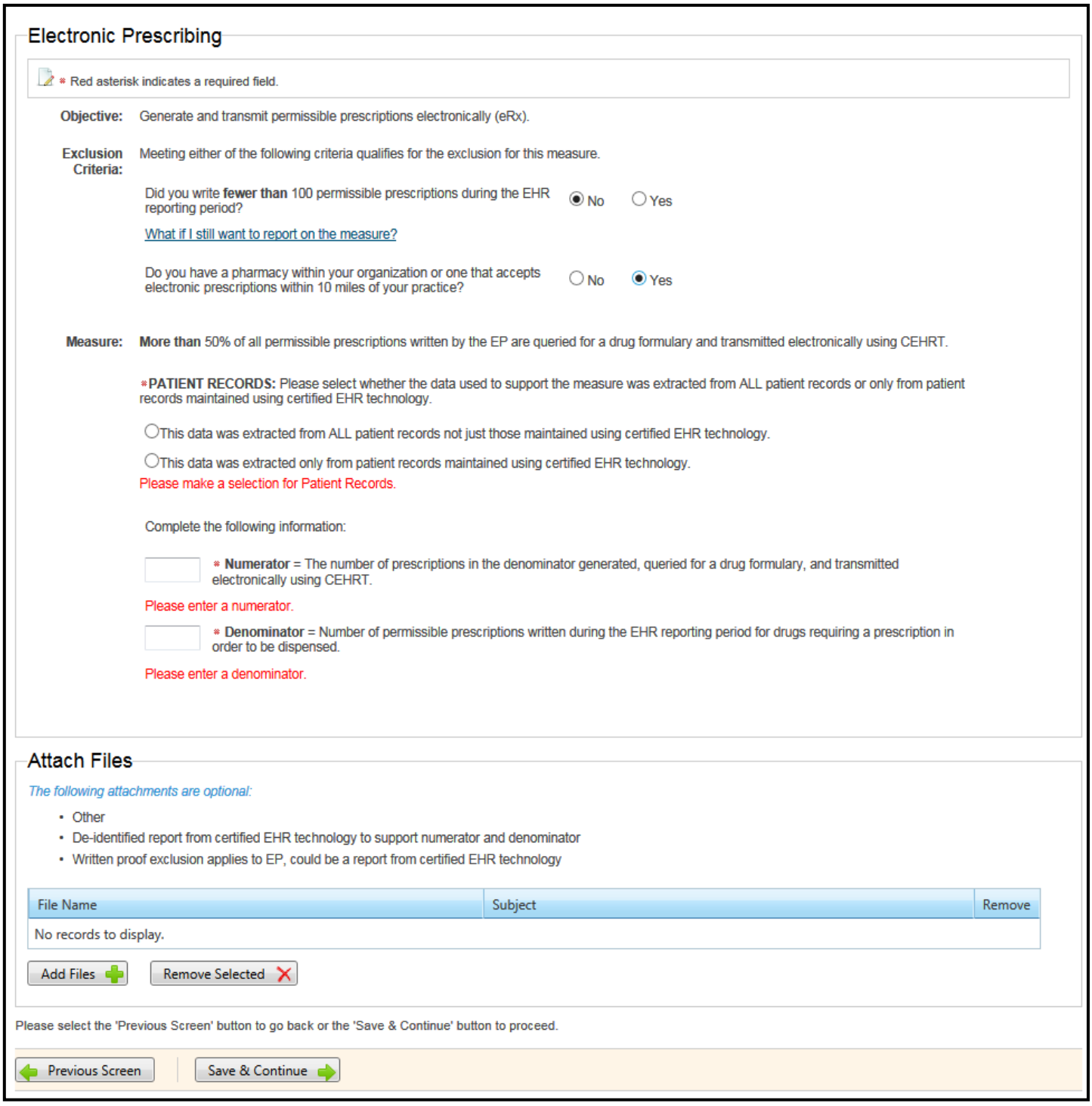
Exclusions


Electronic Prescribing
* Red asterisk indicates a required field.
Objective: Generate and transmit permissible prescriptions electronically (eRx).
Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.
Did you write fewer than 100 permissible prescriptions during the EHR reporting period? No Yes
What if I still want to report on the measure?
Do you have a pharmacy within your organization or one that accepts electronic prescriptions within 10 miles of your practice? No Yes
Measure: More than 50% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Attach Files
The following attachments are optional:
Other
De-identified report from certified EHR technology to support numerator and denominator
Written proof exclusion applies to EP, could be a report from certified EHR technology
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Previous Screen
Save & Continue

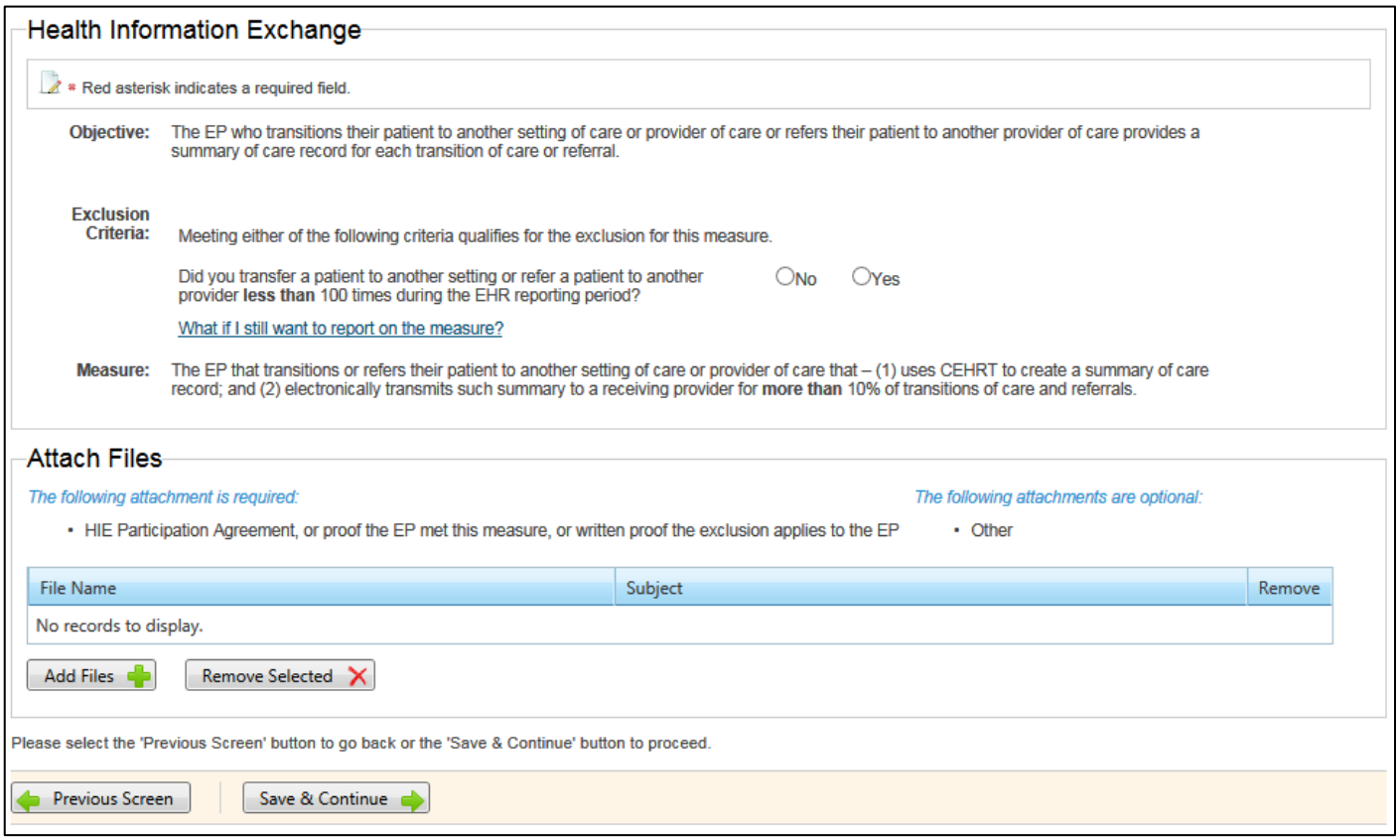

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.
Did you write fewer than 100 permissible prescriptions during the EHR reporting period? No Yes
What if I still want to report on the measure?
Do you have a pharmacy within your organization or one that accepts electronic prescriptions within 10 miles of your practice? No Yes
Measure: More than 50% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.



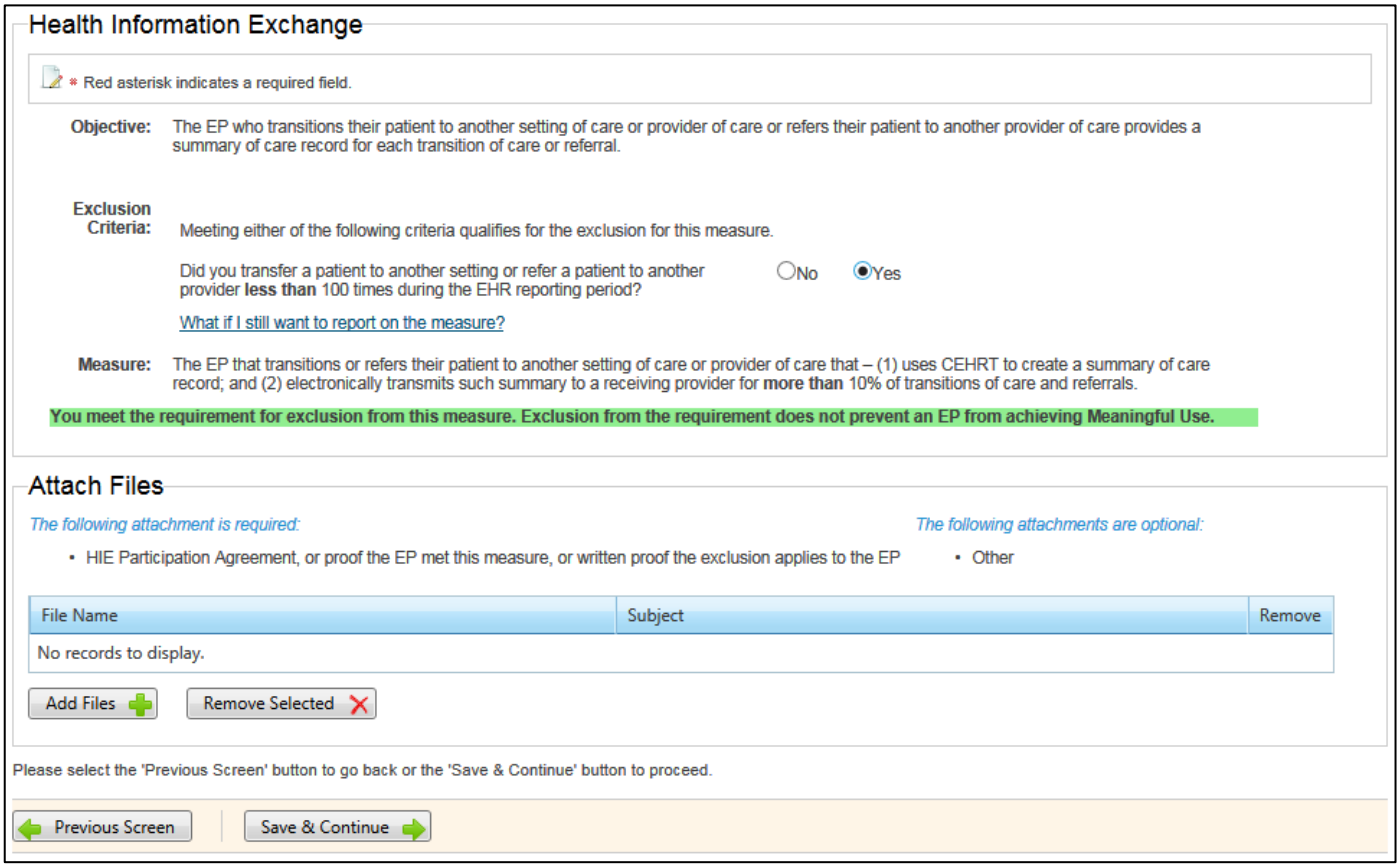
Reporting on the Measure



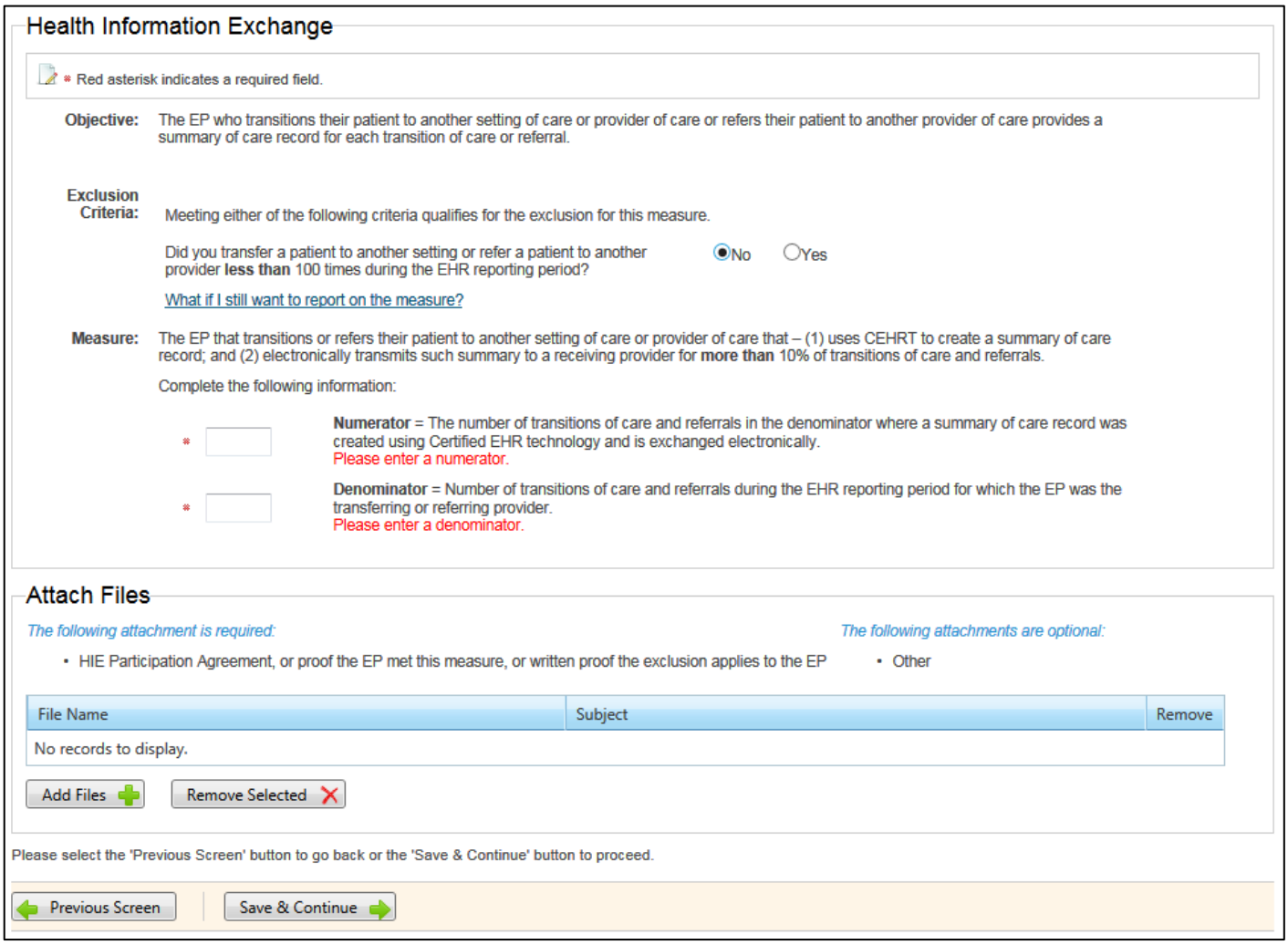
Health Information Exchange



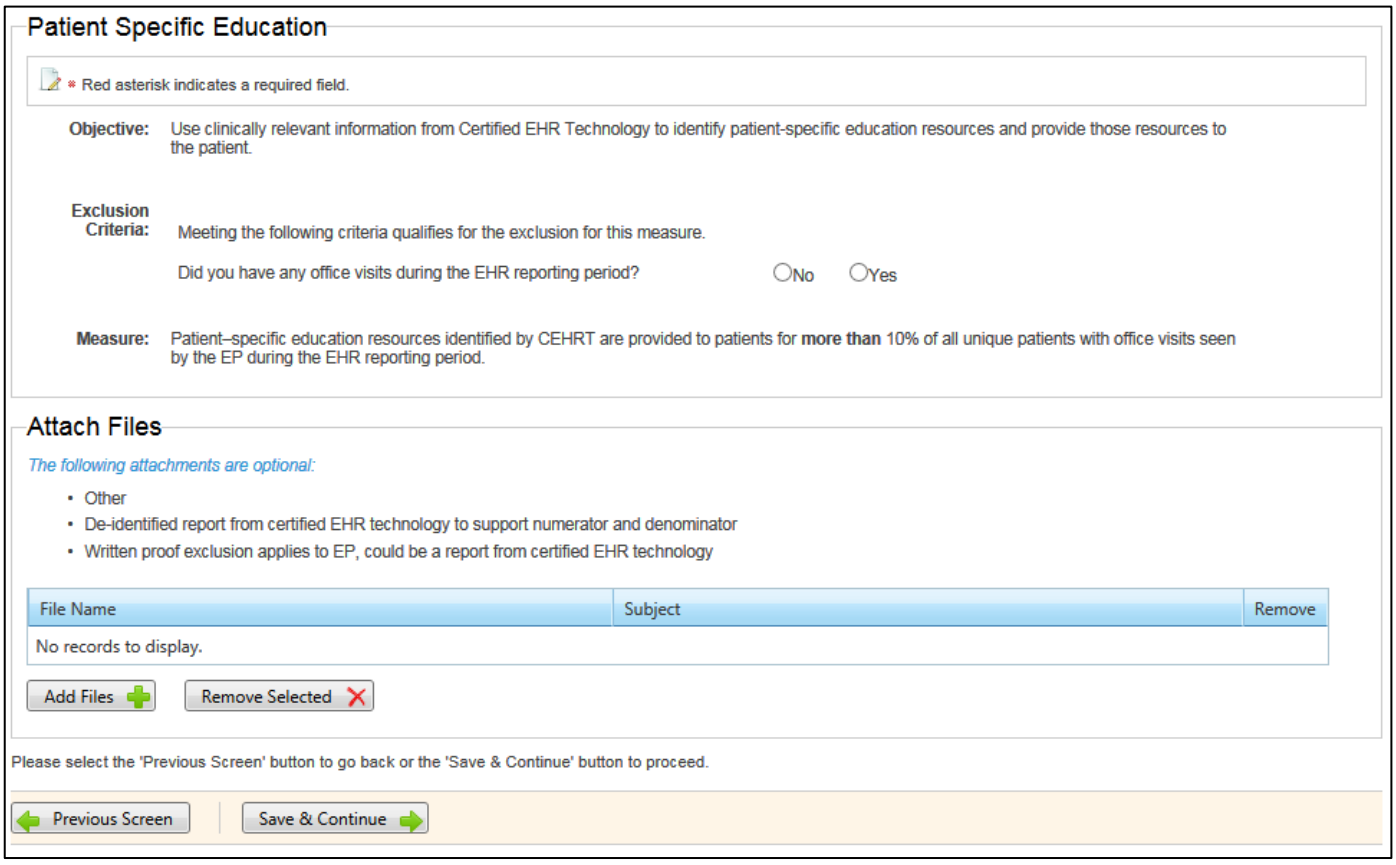
Exclusion



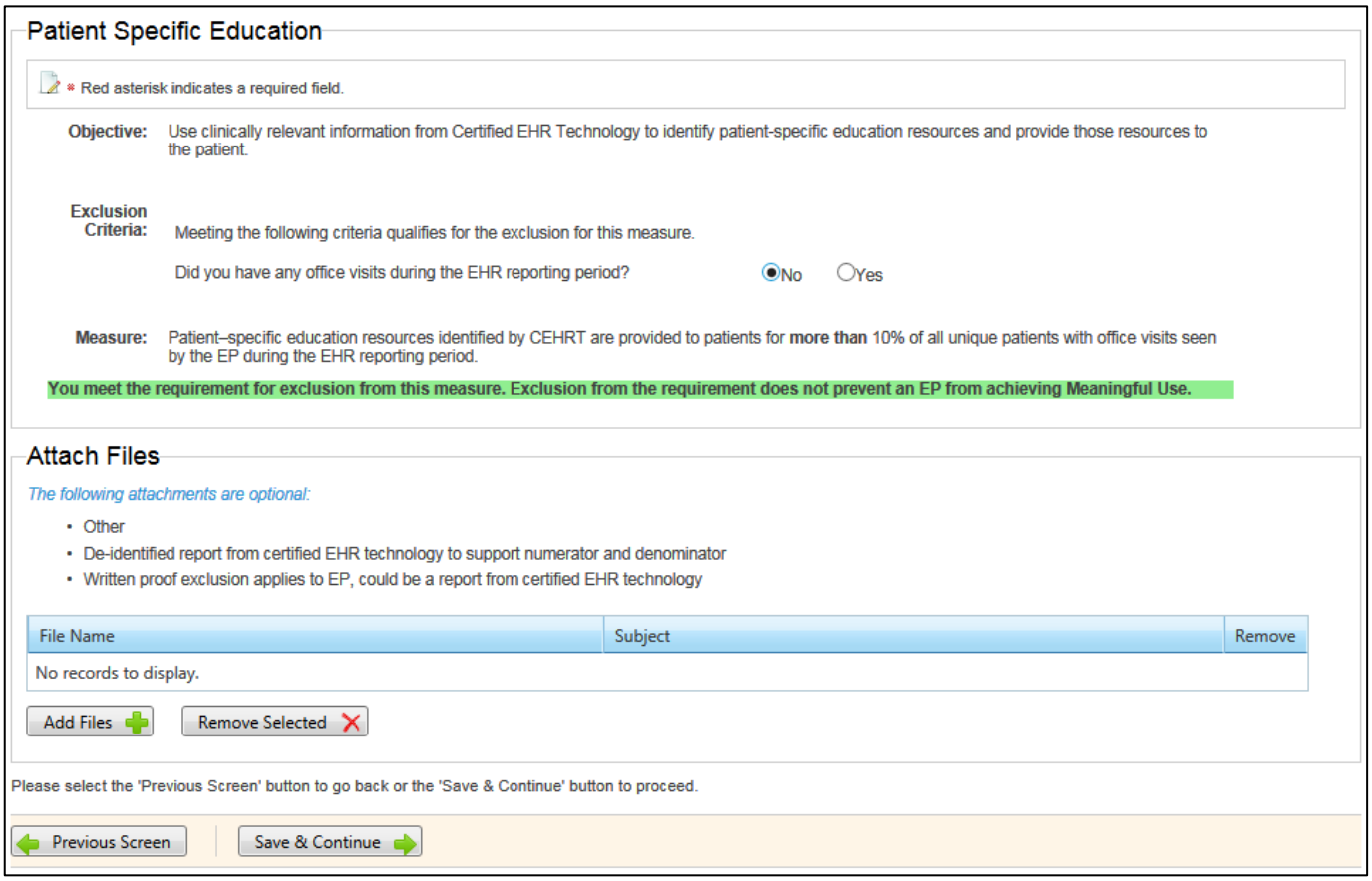
Reporting on the Measure



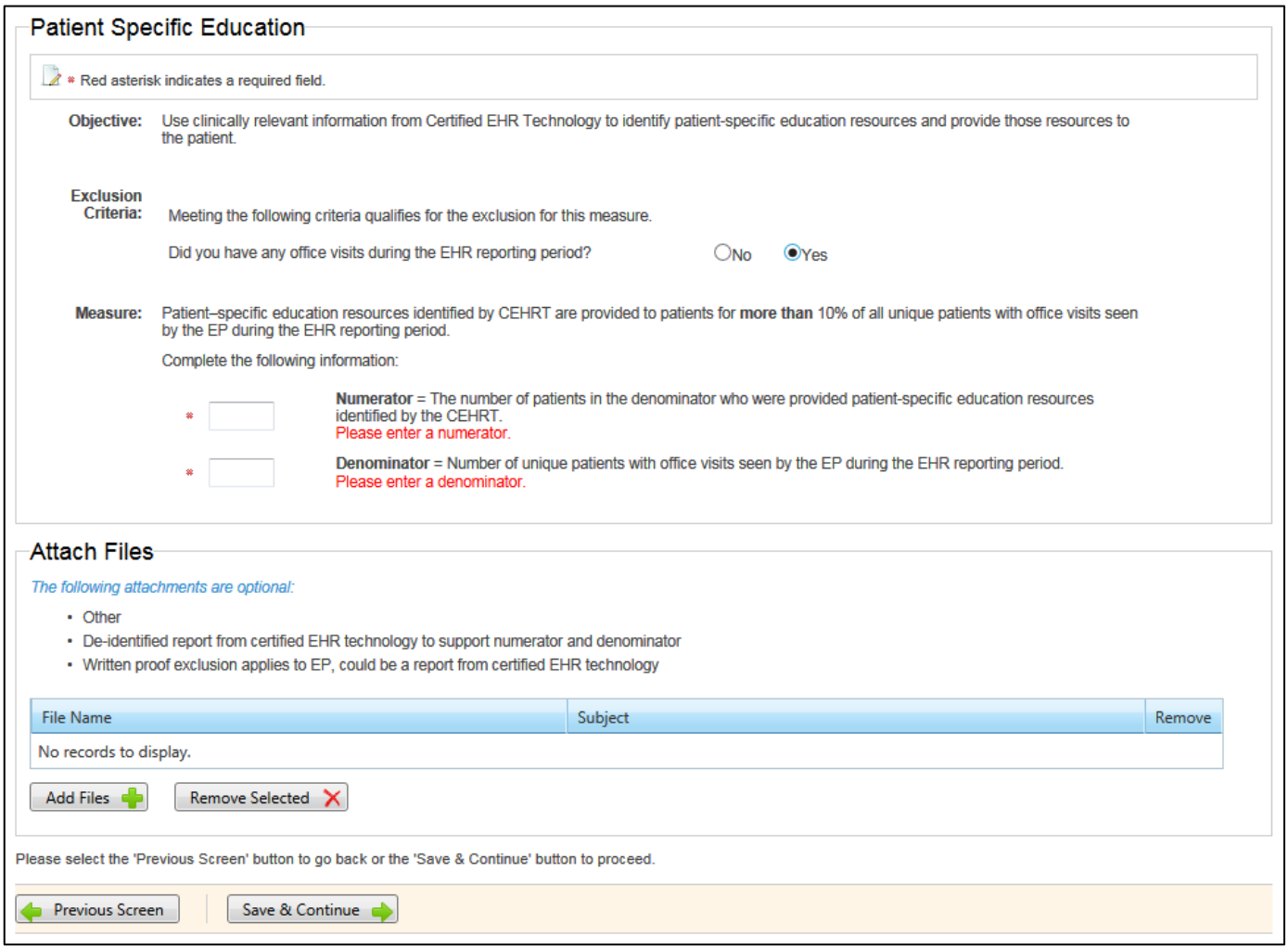
Patient Specific Education



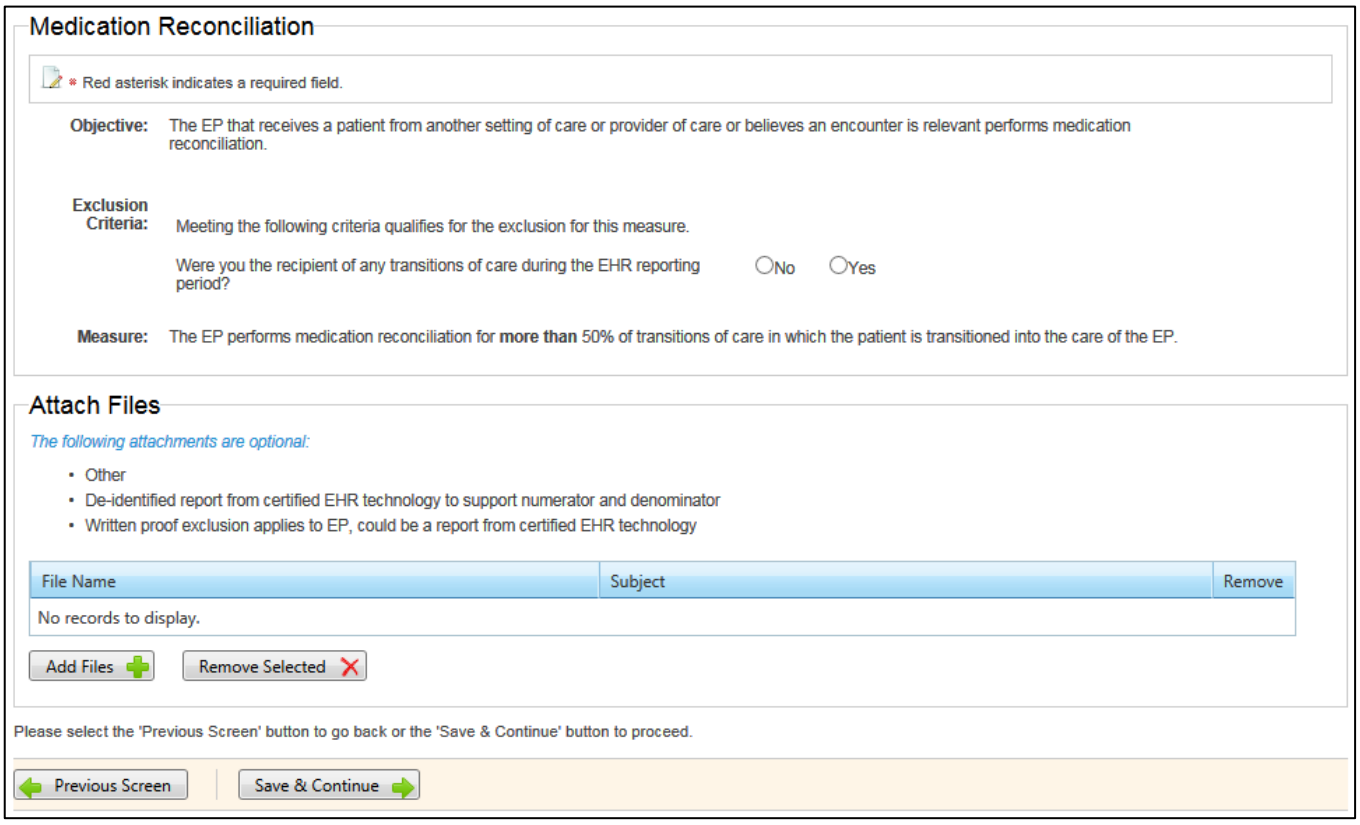
Exclusion



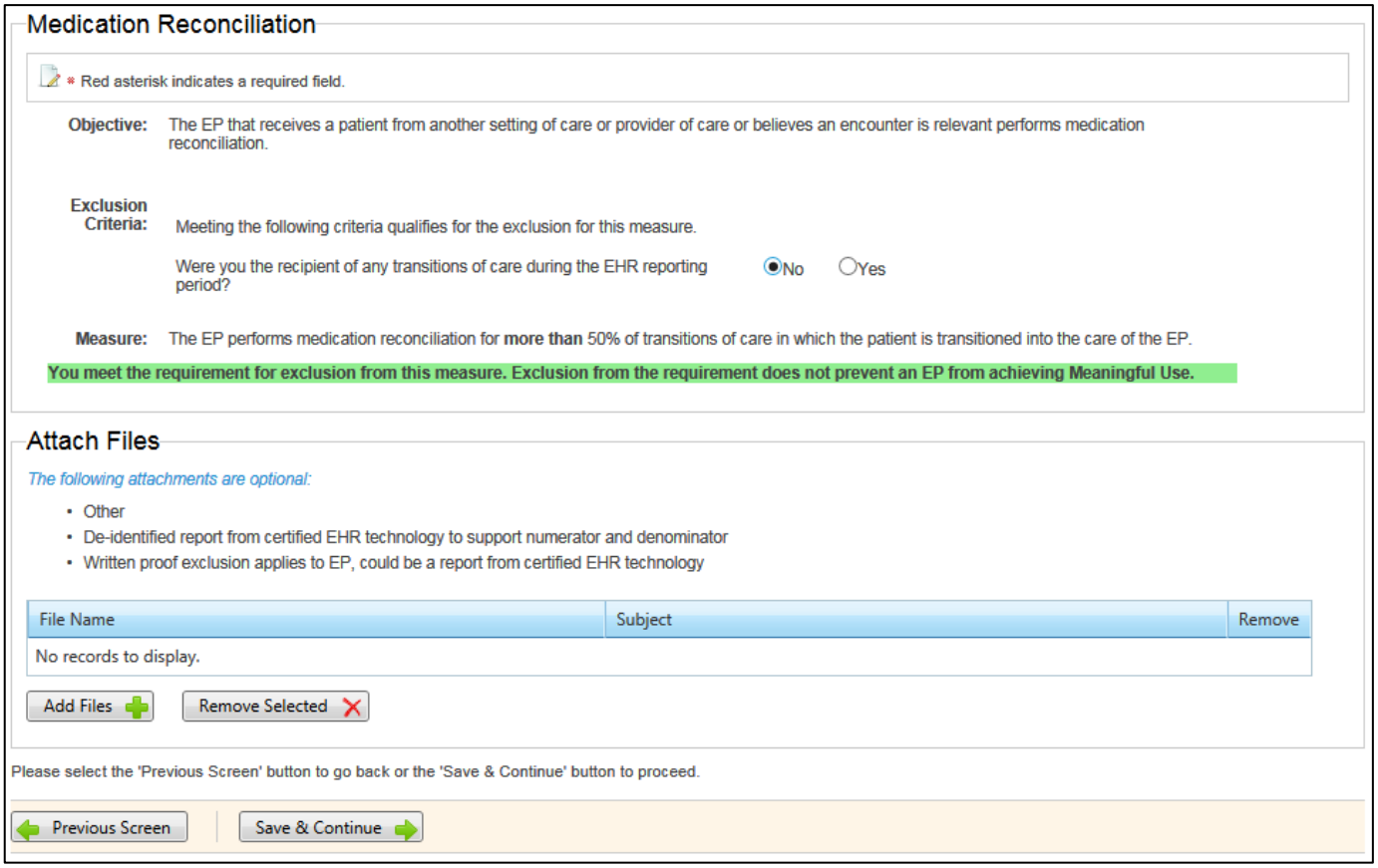
Reporting on the Measure



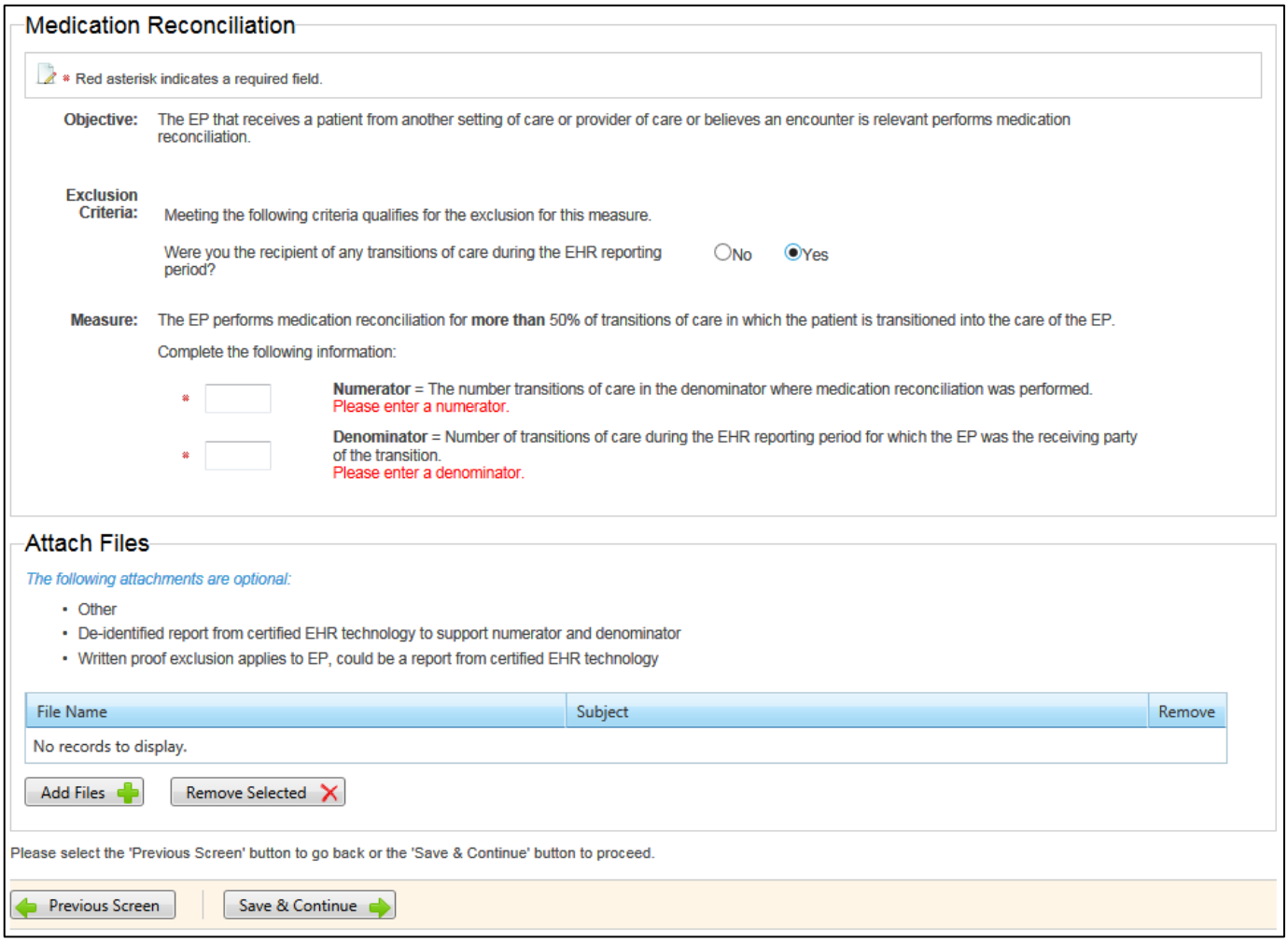
Medication Reconciliation

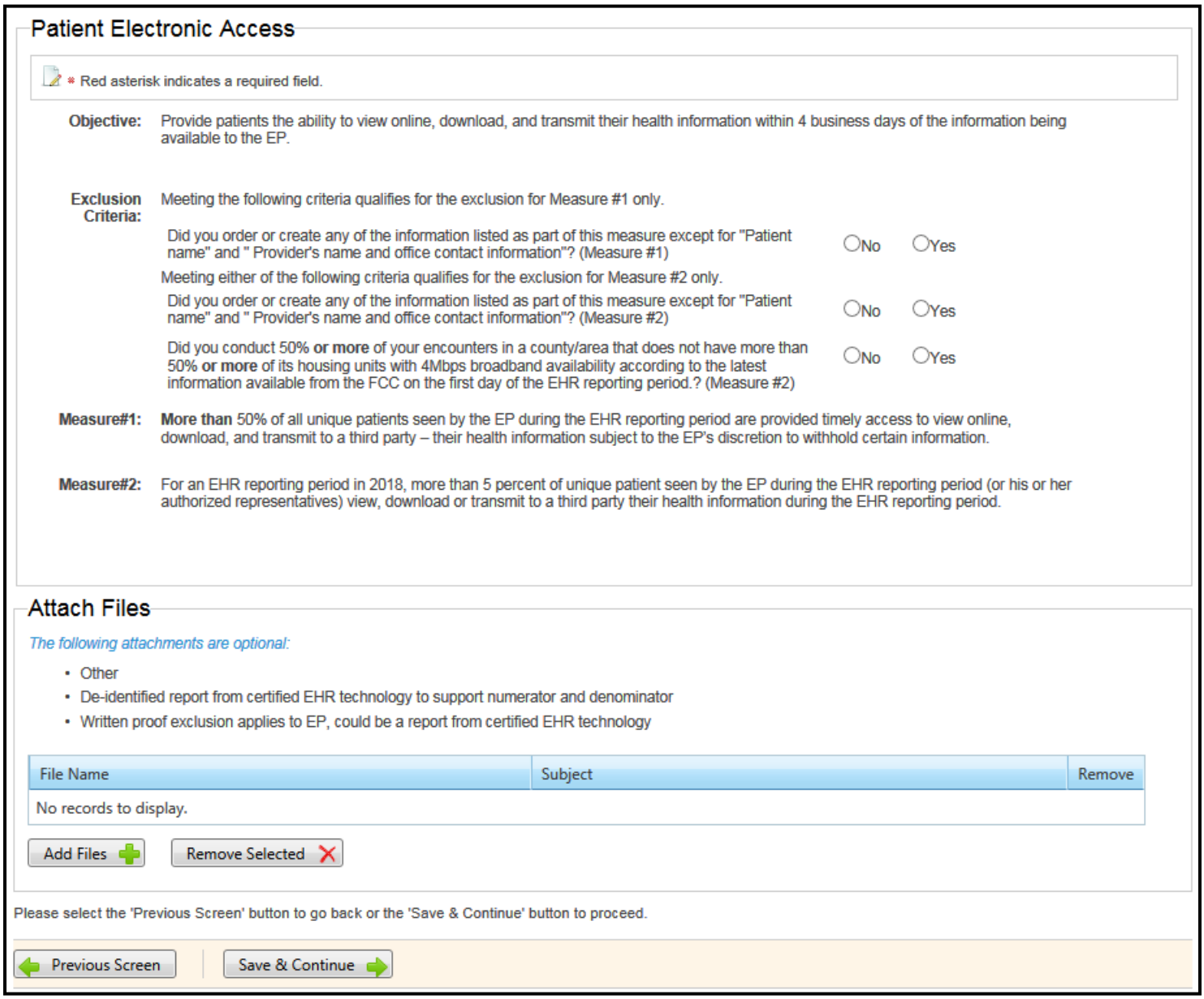


Exclusion



Reporting on the Measure


Medication Reconciliation
* Red asterisk indicates a required field.
Objective: The EP that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.
Exclusion Criteria: Meeting the following criteria qualifies for the exclusion for this measure.
Were you the recipient of any transitions of care during the EHR reporting period?
No
Yes
Measure: The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.
Complete the following information:
* Numerator = The number transitions of care in the denominator where medication reconciliation was performed.
Please enter a numerator.
* Denominator = Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
Please enter a denominator.
Attach Files
The following attachments are optional:
Other
De-identified report from certified EHR technology to support numerator and denominator
Written proof exclusion applies to EP, could be a report from certified EHR technology
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Previous Screen
Save & Continue



Patient Electronic Access

* Red asterisk indicates a required field.

Objective: Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

Exclusion Criteria: Meeting the following criteria qualifies for the exclusion for Measure #1 only.

Did you order or create any of the information listed as part of this measure except for "Patient name" and " Provider's name and office contact information"? (Measure #1) ○No ○Yes

Meeting either of the following criteria qualifies for the exclusion for Measure #2 only.

Did you order or create any of the information listed as part of this measure except for "Patient name" and " Provider's name and office contact information"? (Measure #2) ○No ○Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.? (Measure #2) ○No ○Yes

Measure#1: **More than** 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party – their health information subject to the EP's discretion to withhold certain information.

Measure#2: For an EHR reporting period in 2018, more than 5 percent of unique patient seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

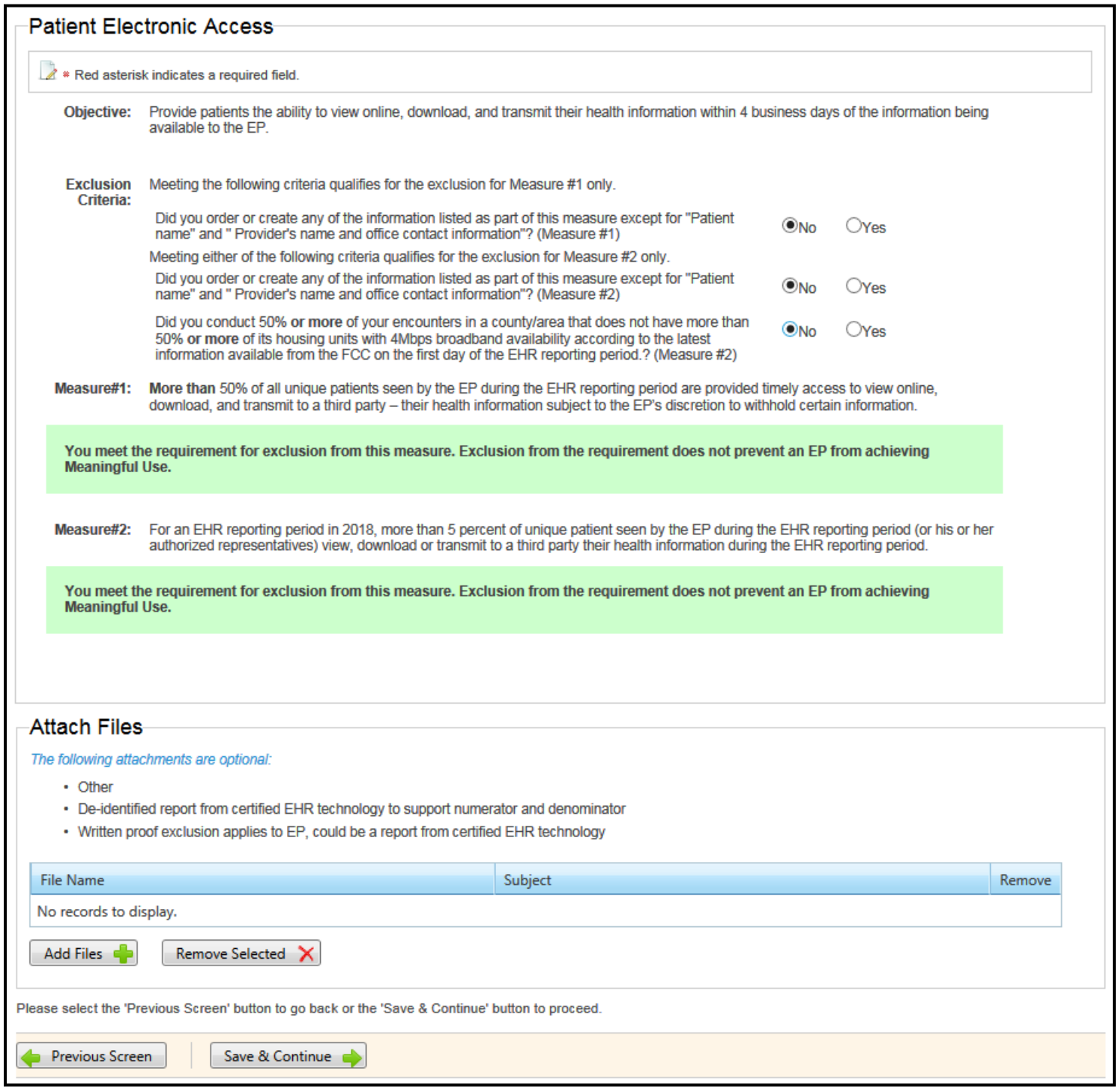
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Exclusions



Patient Electronic Access

* Red asterisk indicates a required field.

Objective: Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

Exclusion Criteria: Meeting the following criteria qualifies for the exclusion for Measure #1 only.

Did you order or create any of the information listed as part of this measure except for "Patient name" and " Provider's name and office contact information"? (Measure #1) — ◉No ○Yes

Meeting either of the following criteria qualifies for the exclusion for Measure #2 only.

Did you order or create any of the information listed as part of this measure except for "Patient name" and " Provider's name and office contact information"? (Measure #2) — ◉No ○Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.? (Measure #2) — ◉No ○Yes

Measure#1: **More than** 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party – their health information subject to the EP's discretion to withhold certain information.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#2: For an EHR reporting period in 2018, more than 5 percent of unique patient seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

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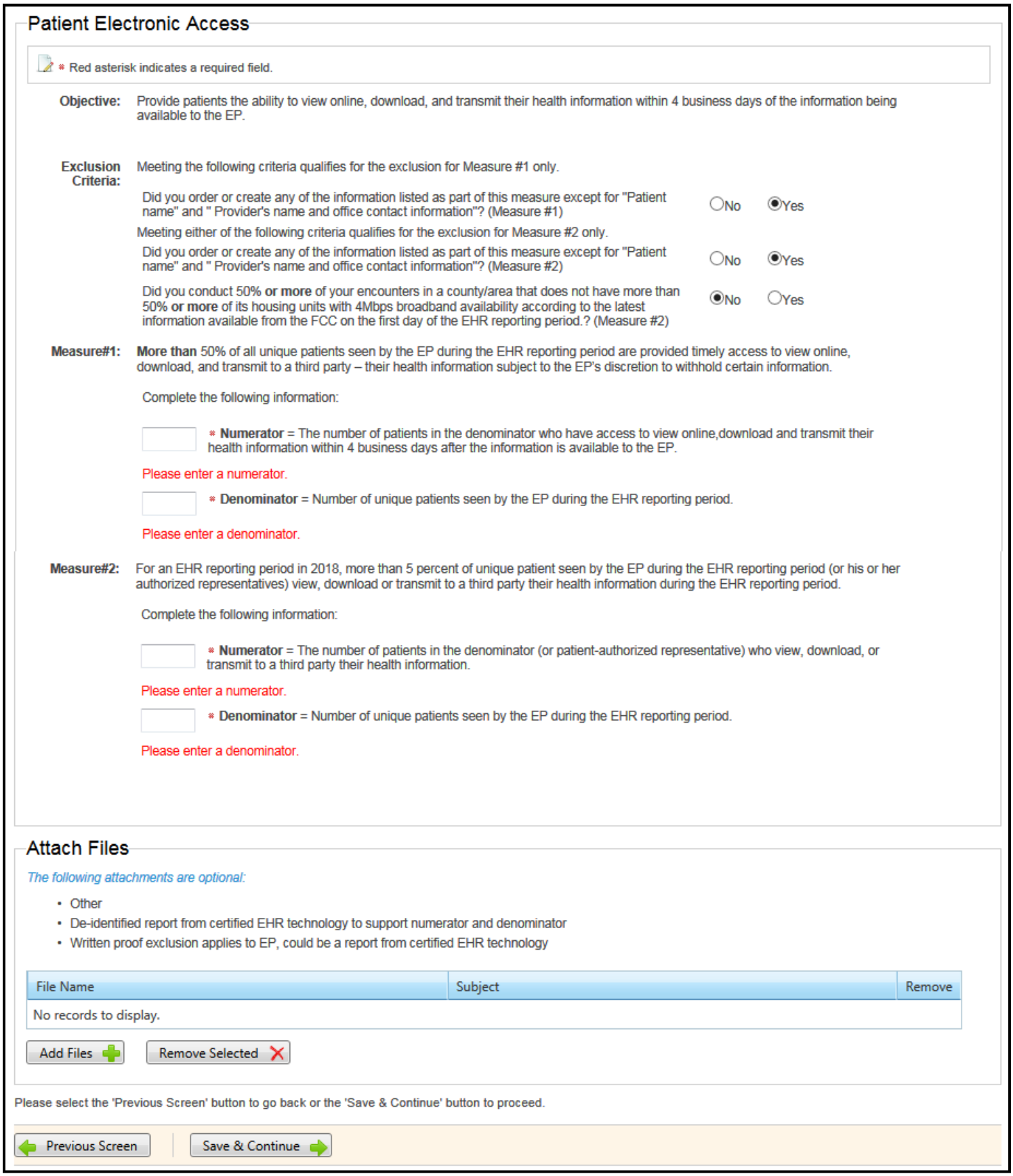
Previous Screen | Save & Continue



Patient Electronic Access

* Red asterisk indicates a required field.

Objective: Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

Exclusion Criteria: Meeting the following criteria qualifies for the exclusion for Measure #1 only.

Did you order or create any of the information listed as part of this measure except for "Patient name" and " Provider's name and office contact information"? (Measure #1) ○No ◉Yes

Meeting either of the following criteria qualifies for the exclusion for Measure #2 only.

Did you order or create any of the information listed as part of this measure except for "Patient name" and " Provider's name and office contact information"? (Measure #2) ○No ◉Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.? (Measure #2) ◉No ○Yes

Measure#1: **More than** 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party – their health information subject to the EP's discretion to withhold certain information.

Complete the following information:

* **Numerator** = The number of patients in the denominator who have access to view online,download and transmit their health information within 4 business days after the information is available to the EP.

Please enter a numerator.

* **Denominator** = Number of unique patients seen by the EP during the EHR reporting period.

Please enter a denominator.

Measure#2: For an EHR reporting period in 2018, more than 5 percent of unique patient seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.

Complete the following information:

* **Numerator** = The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.

Please enter a numerator.

* **Denominator** = Number of unique patients seen by the EP during the EHR reporting period.

Please enter a denominator.

Attach Files

The following attachments are optional:

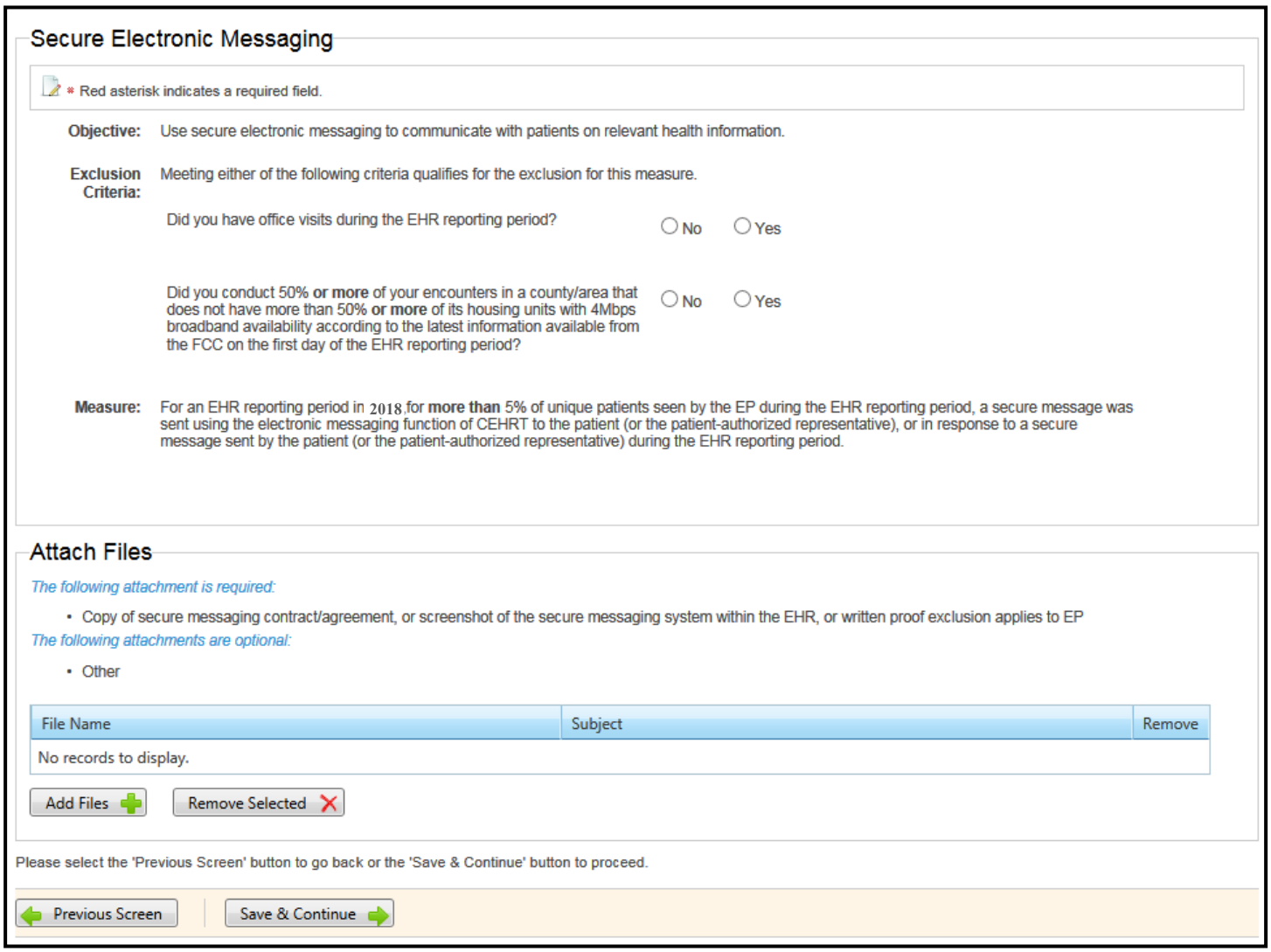
- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue



Secure Electronic Messaging

* Red asterisk indicates a required field.

Objective: Use secure electronic messaging to communicate with patients on relevant health information.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have office visits during the EHR reporting period? ○ No ○ Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? ○ No ○ Yes

Measure: For an EHR reporting period in 2018, for **more than** 5% of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

Attach Files

The following attachment is required:

- Copy of secure messaging contract/agreement, or screenshot of the secure messaging system within the EHR, or written proof exclusion applies to EP

The following attachments are optional:

- Other

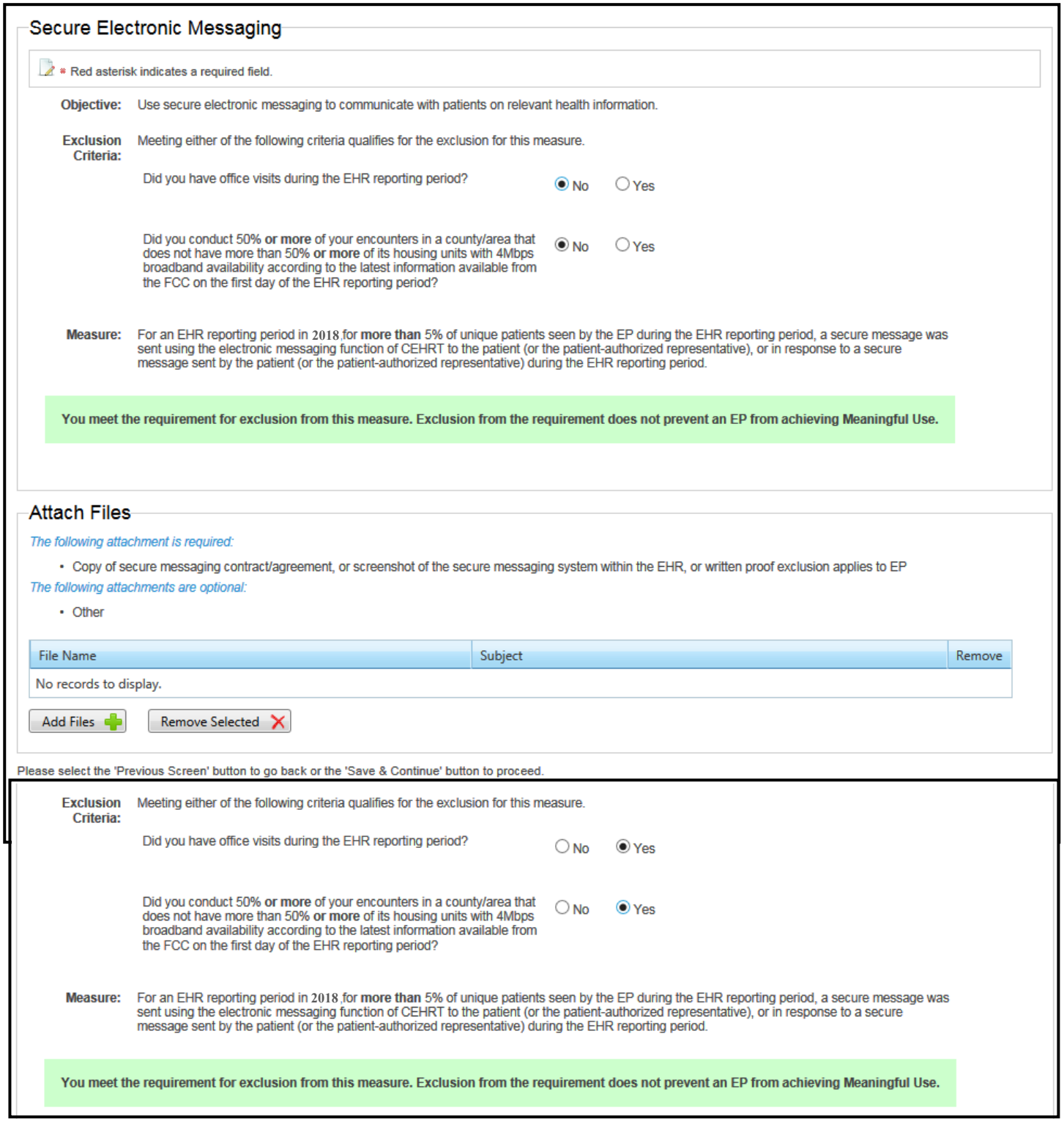
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

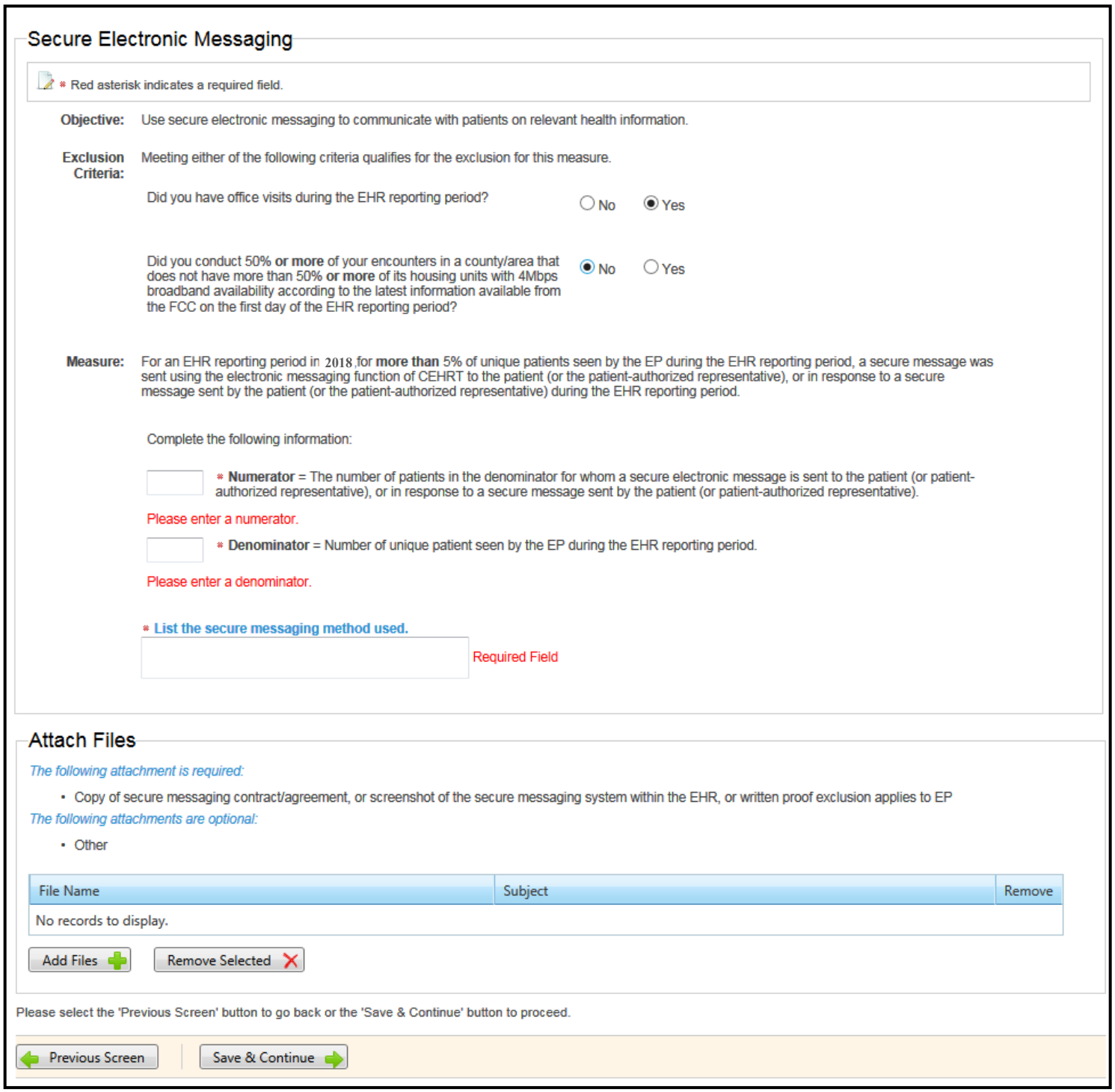
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Exclusions



Reporting on the Measure



Secure Electronic Messaging

* Red asterisk indicates a required field.

Objective: Use secure electronic messaging to communicate with patients on relevant health information.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have office visits during the EHR reporting period? ○ No ◉ Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? ◉ No ○ Yes

Measure: For an EHR reporting period in 2018, for **more than** 5% of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

Complete the following information:

* **Numerator** = The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).

Please enter a numerator.

* **Denominator** = Number of unique patient seen by the EP during the EHR reporting period.

Please enter a denominator.

* **List the secure messaging method used.**

Required Field

Attach Files

The following attachment is required:

- Copy of secure messaging contract/agreement, or screenshot of the secure messaging system within the EHR, or written proof exclusion applies to EP

The following attachments are optional:

- Other

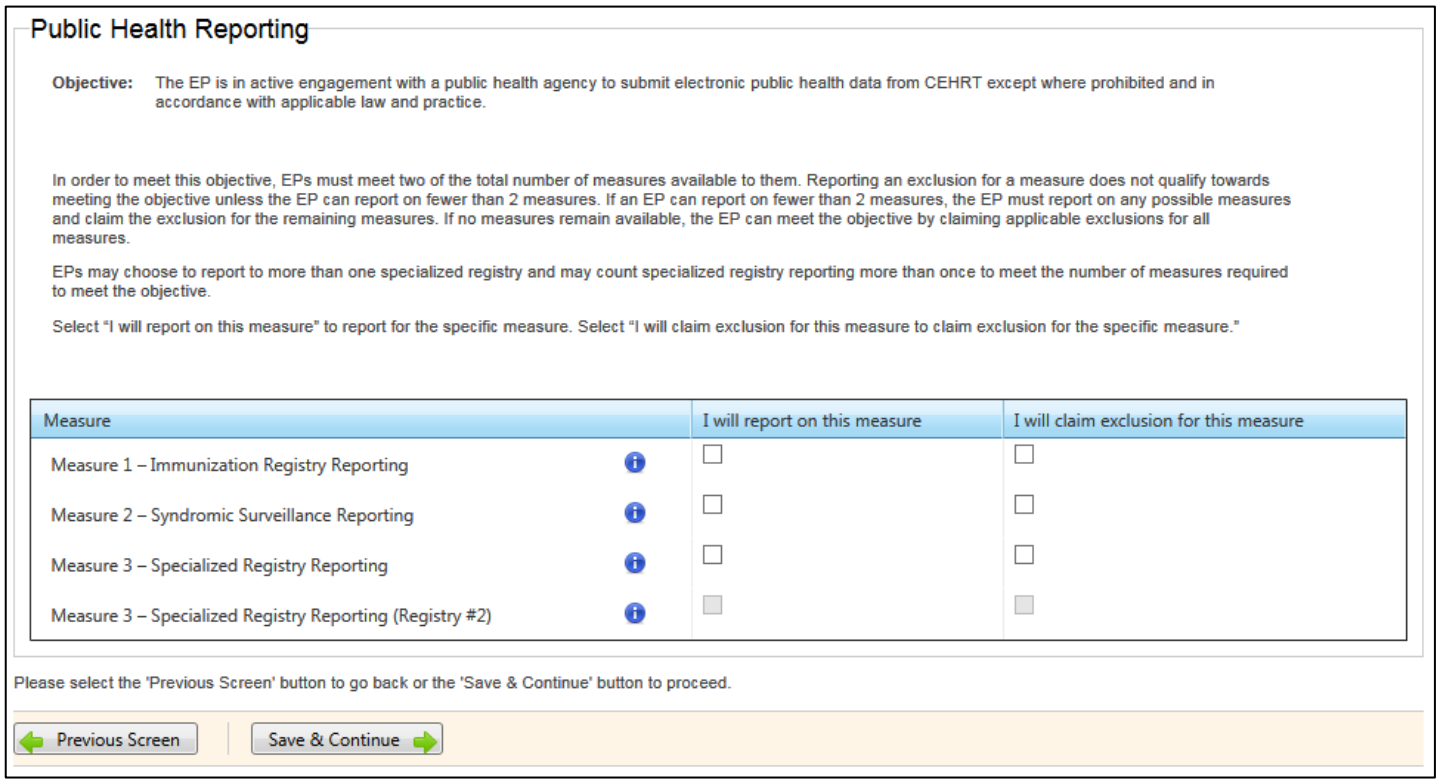
File Name	Subject	Remove
No records to display.		

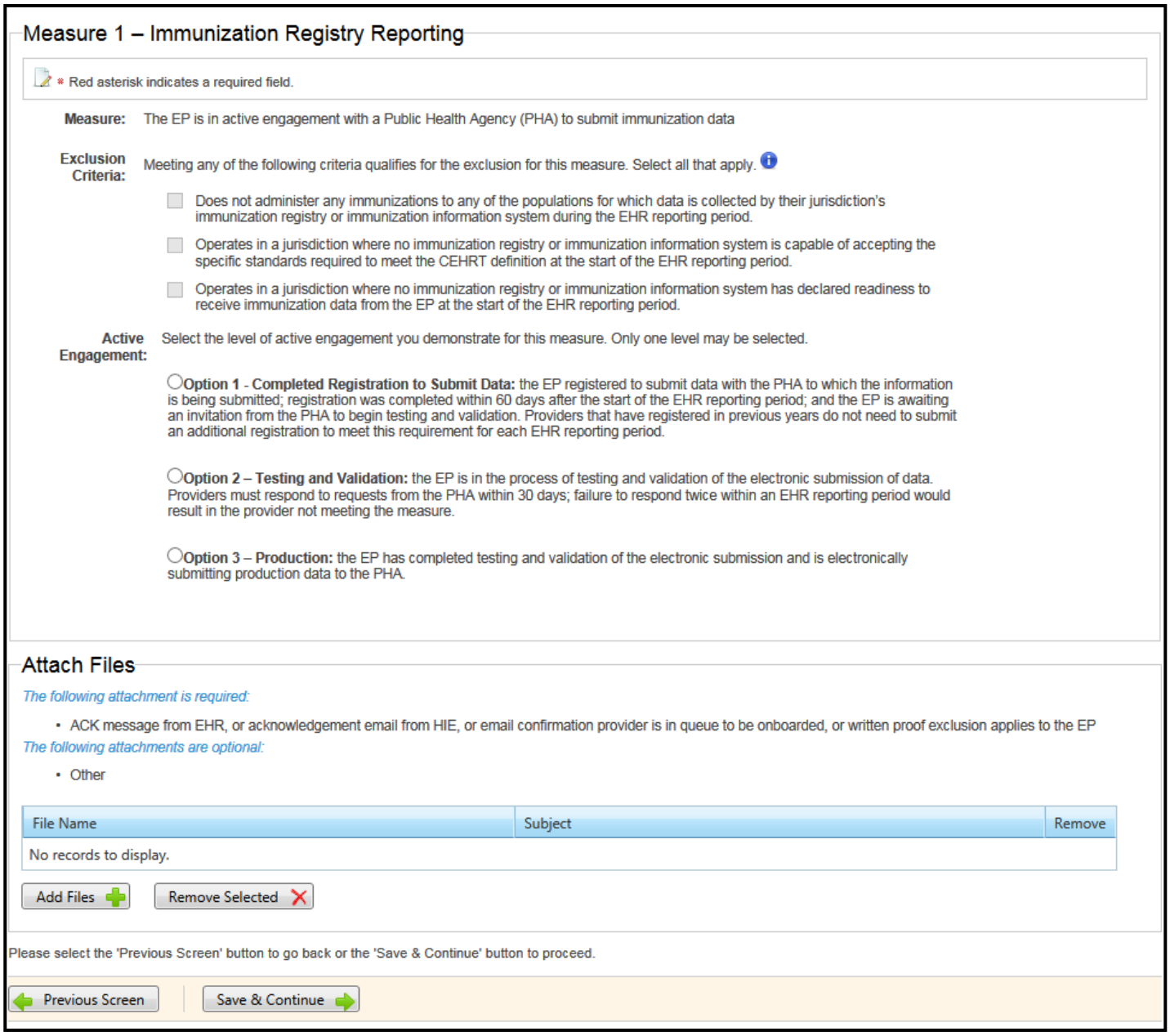
Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Public Health Reporting Selection Page





Measure 1 – Immunization Registry Reporting

* Red asterisk indicates a required field.

Measure: The EP is in active engagement with a Public Health Agency (PHA) to submit immunization data

Exclusion Criteria: Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.

- ☐ Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.
- ☐ Operates in a jurisdiction where no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
- ☐ Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

- ○ **Option 1 - Completed Registration to Submit Data:** the EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
- ○ **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.
- ○ **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

Attach Files

The following attachment is required:

- ACK message from EHR, or acknowledgement email from HIE, or email confirmation provider is in queue to be onboarded, or written proof exclusion applies to the EP

The following attachments are optional:

- Other

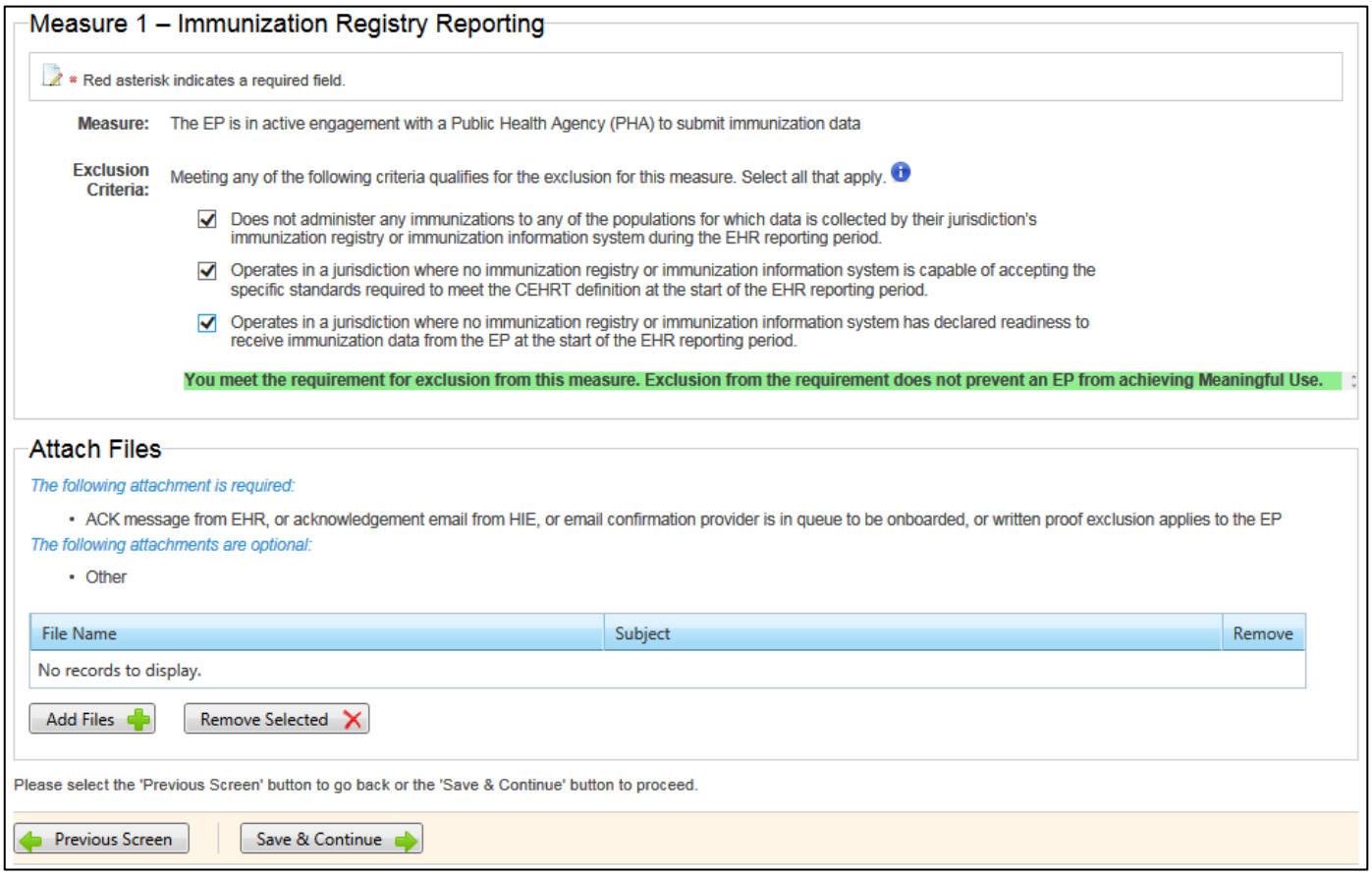
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

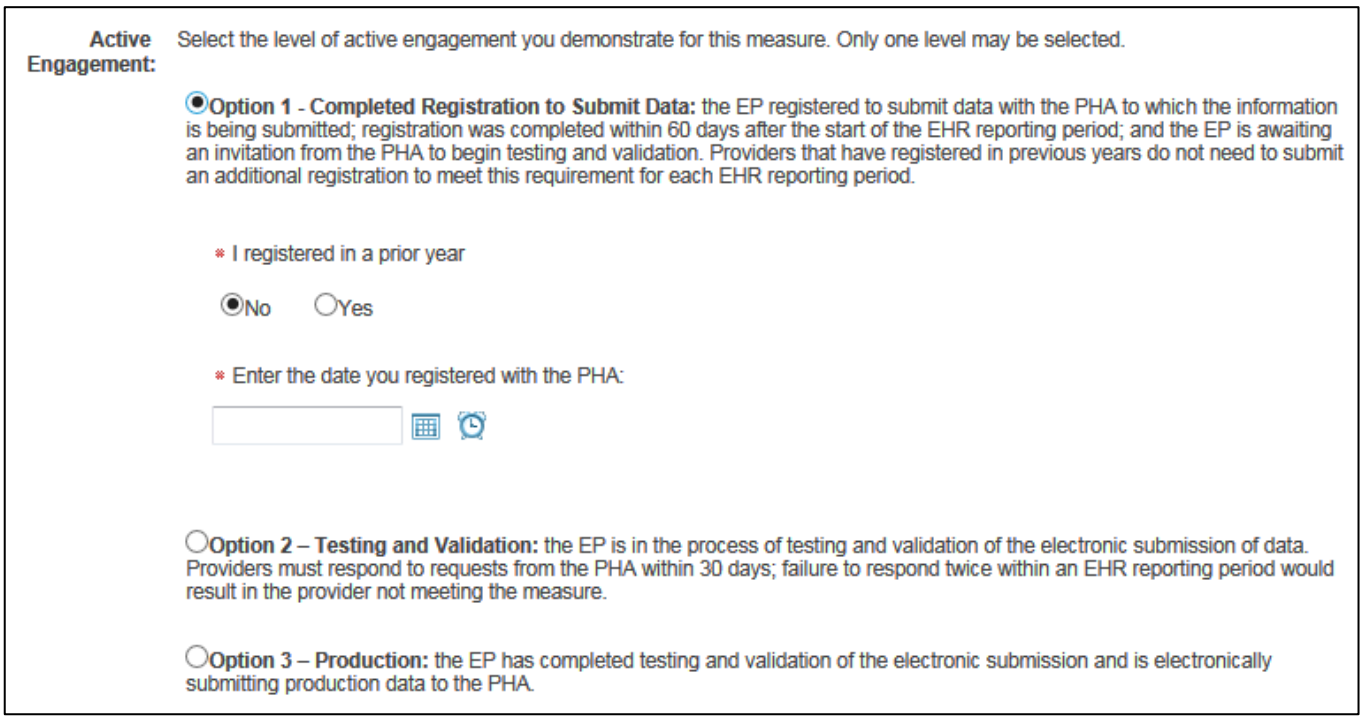
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

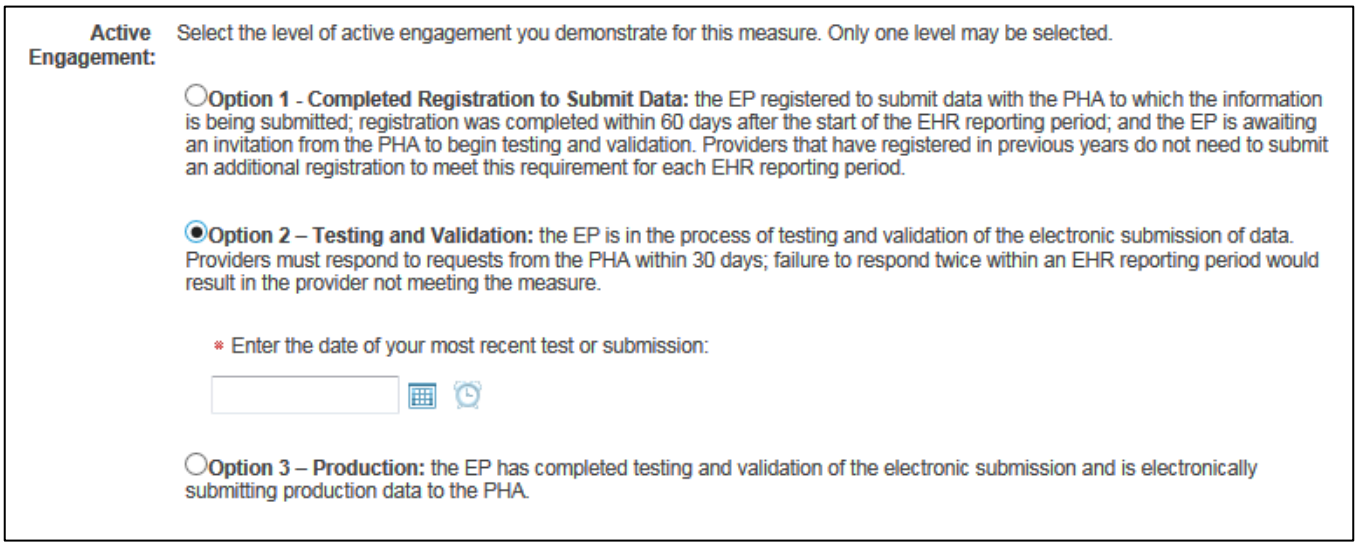
Exclusions



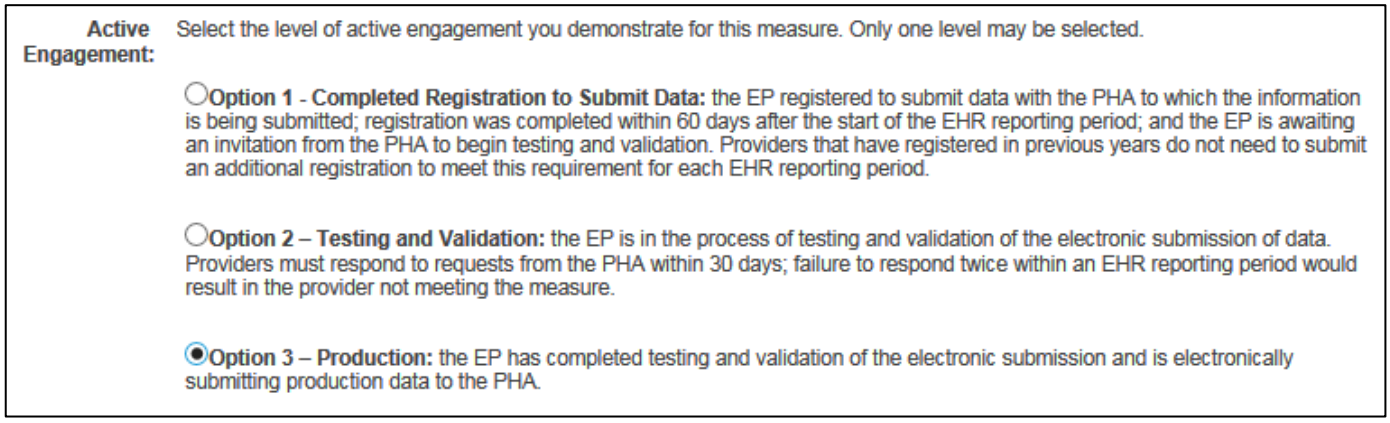
Active Engagement Option 1- Completed Registration to Submit Data

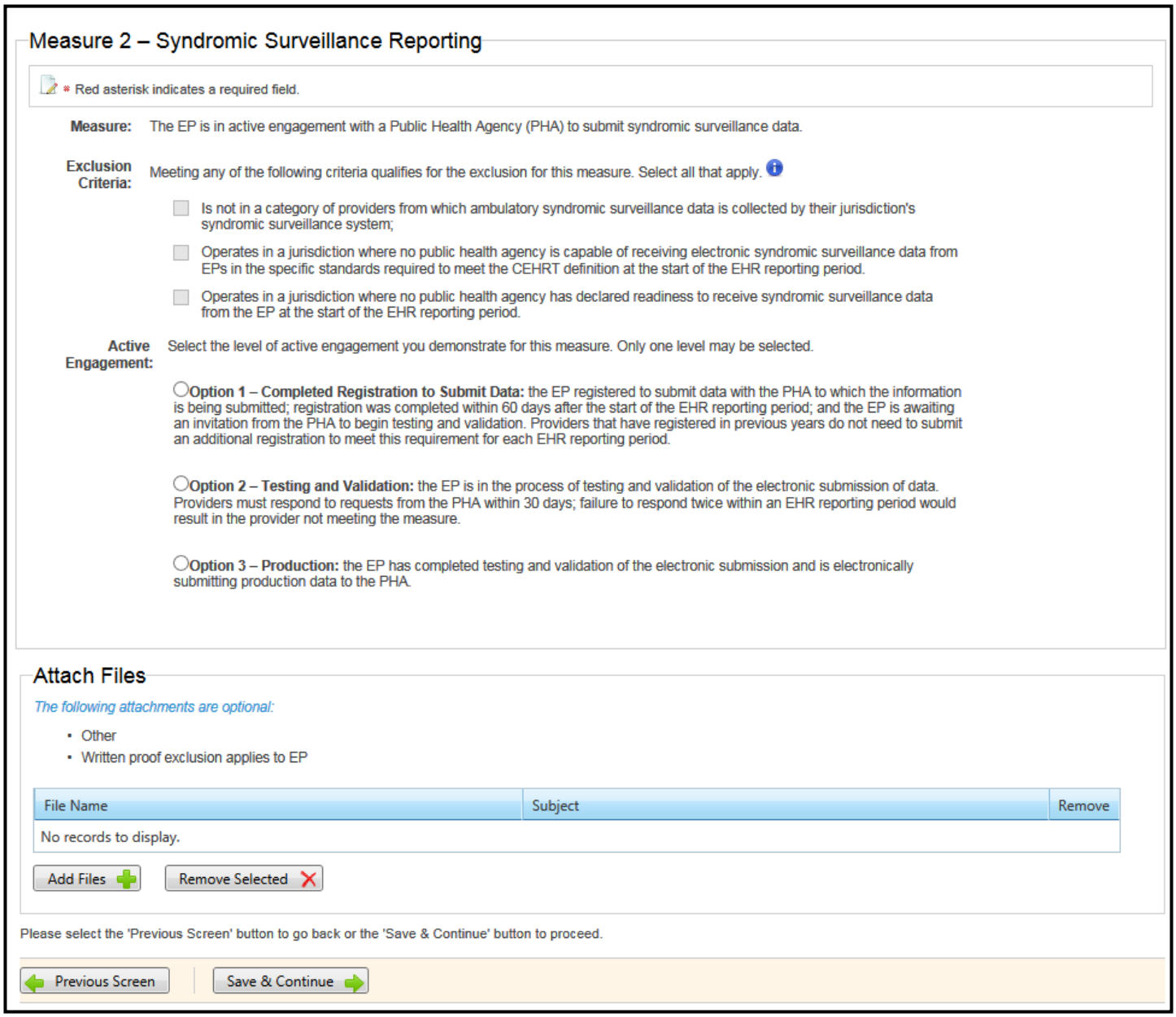


Active Engagement Option 2- Testing and Validation



Active Engagement Option 3- Production





Measure 2 – Syndromic Surveillance Reporting

* Red asterisk indicates a required field.

Measure: The EP is in active engagement with a Public Health Agency (PHA) to submit syndromic surveillance data.

Exclusion Criteria: Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.

- ☐ Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
- ☐ Operates in a jurisdiction where no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
- ☐ Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from the EP at the start of the EHR reporting period.

Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

- ○ **Option 1 – Completed Registration to Submit Data:** the EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
- ○ **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.
- ○ **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

Attach Files

The following attachments are optional:

- Other
- Written proof exclusion applies to EP

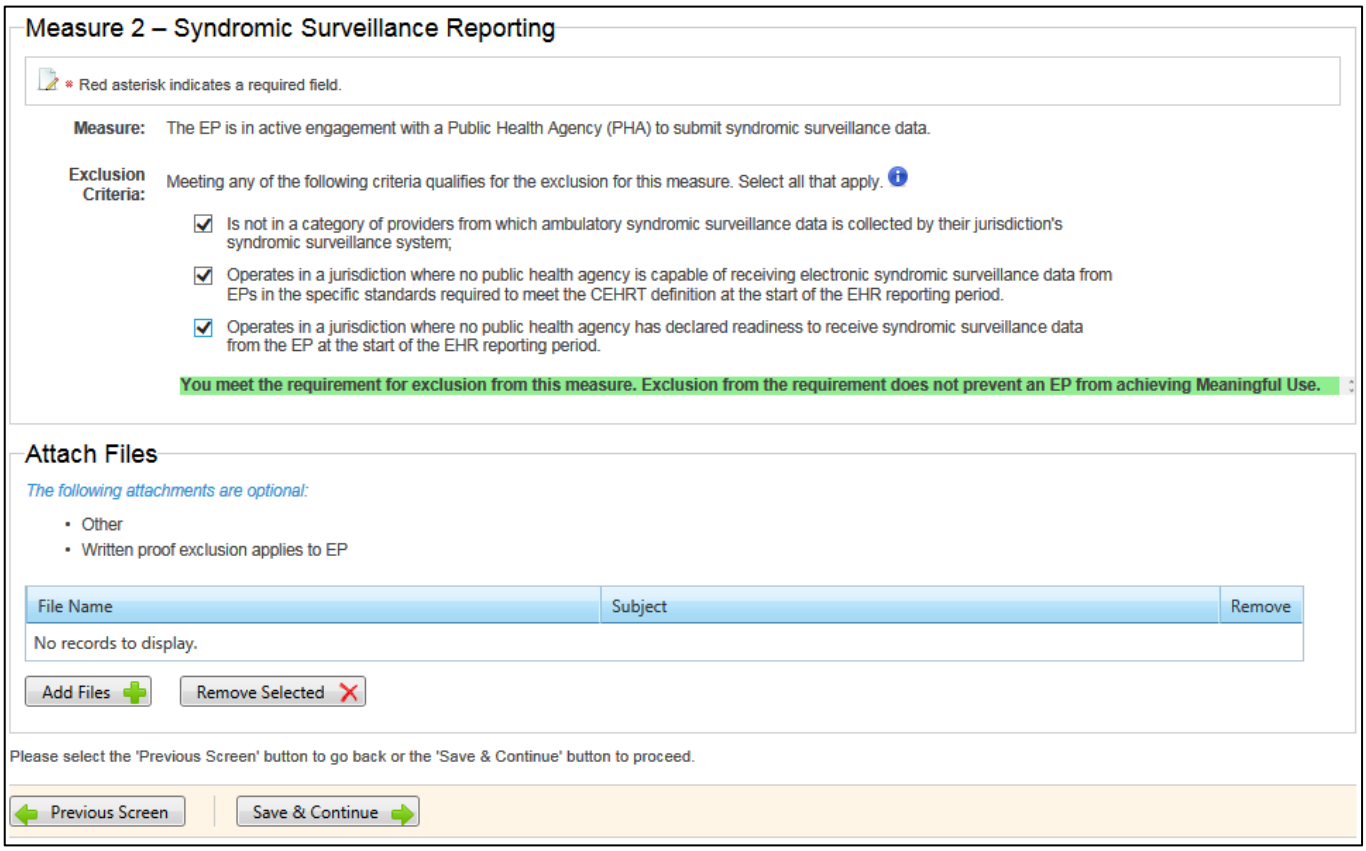
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

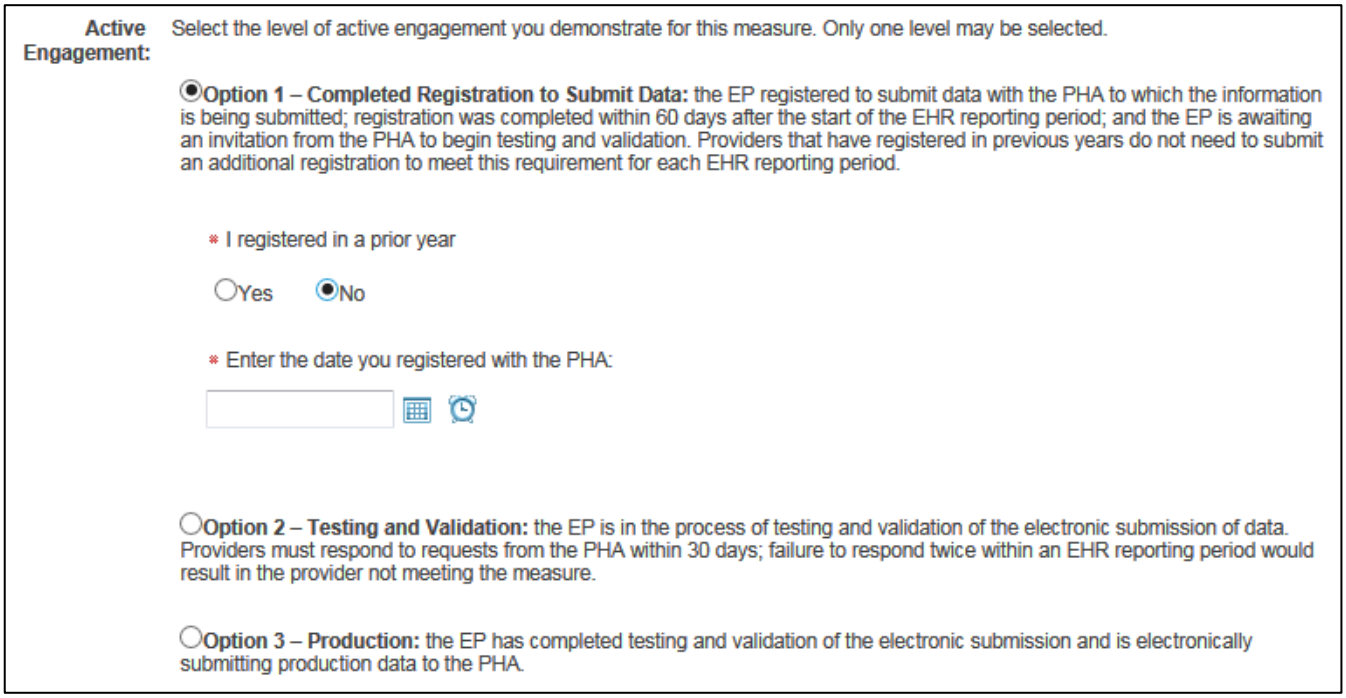
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

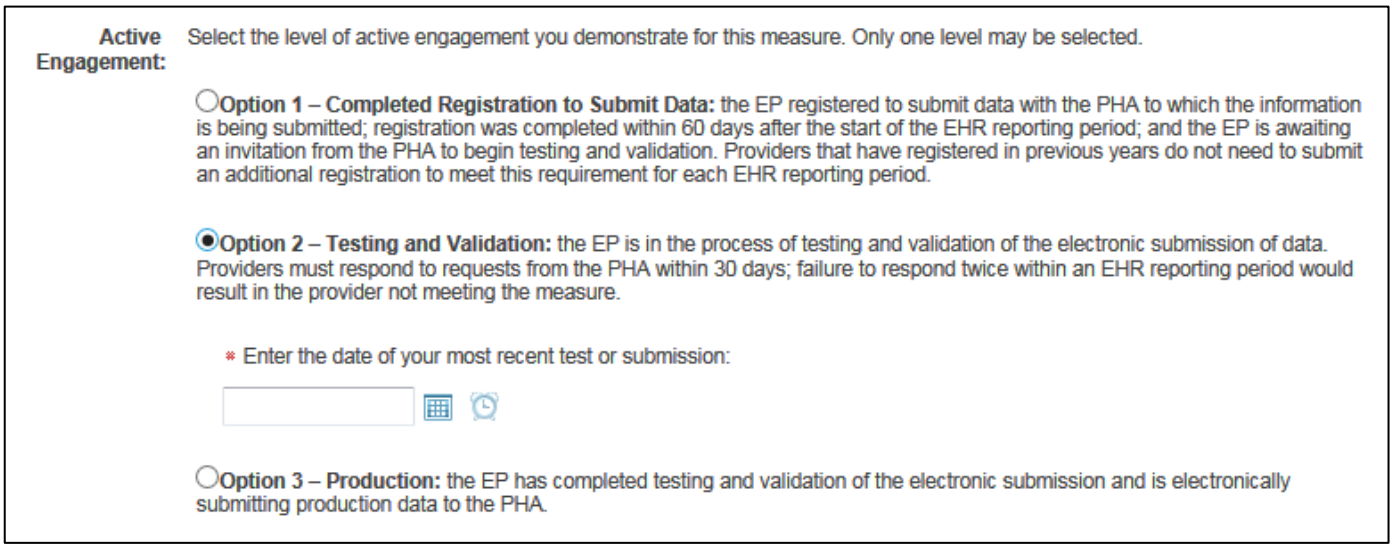
Exclusions



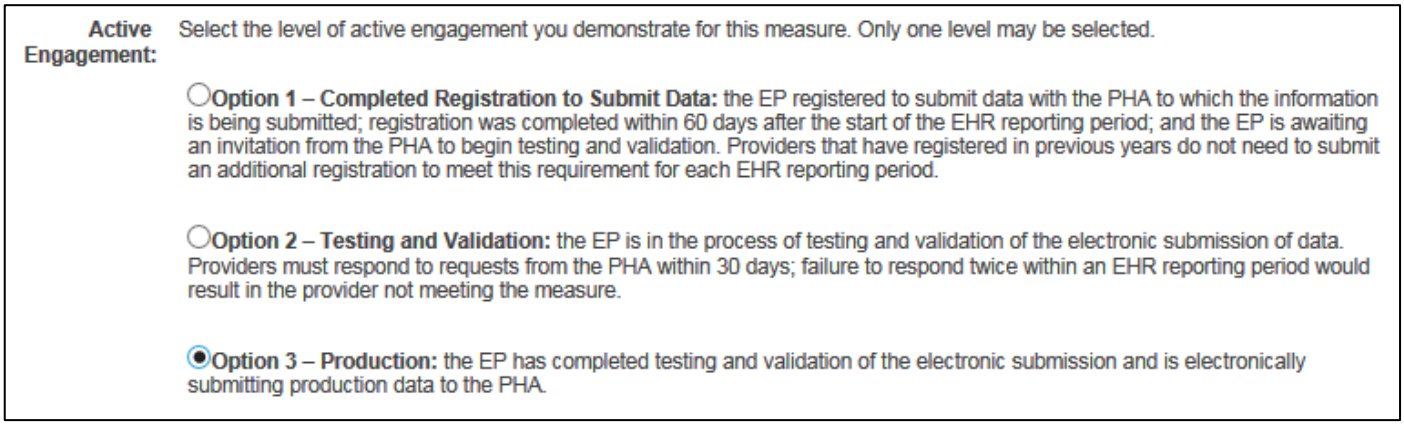
Active Engagement Option 1- Completed Registration to Submit Data



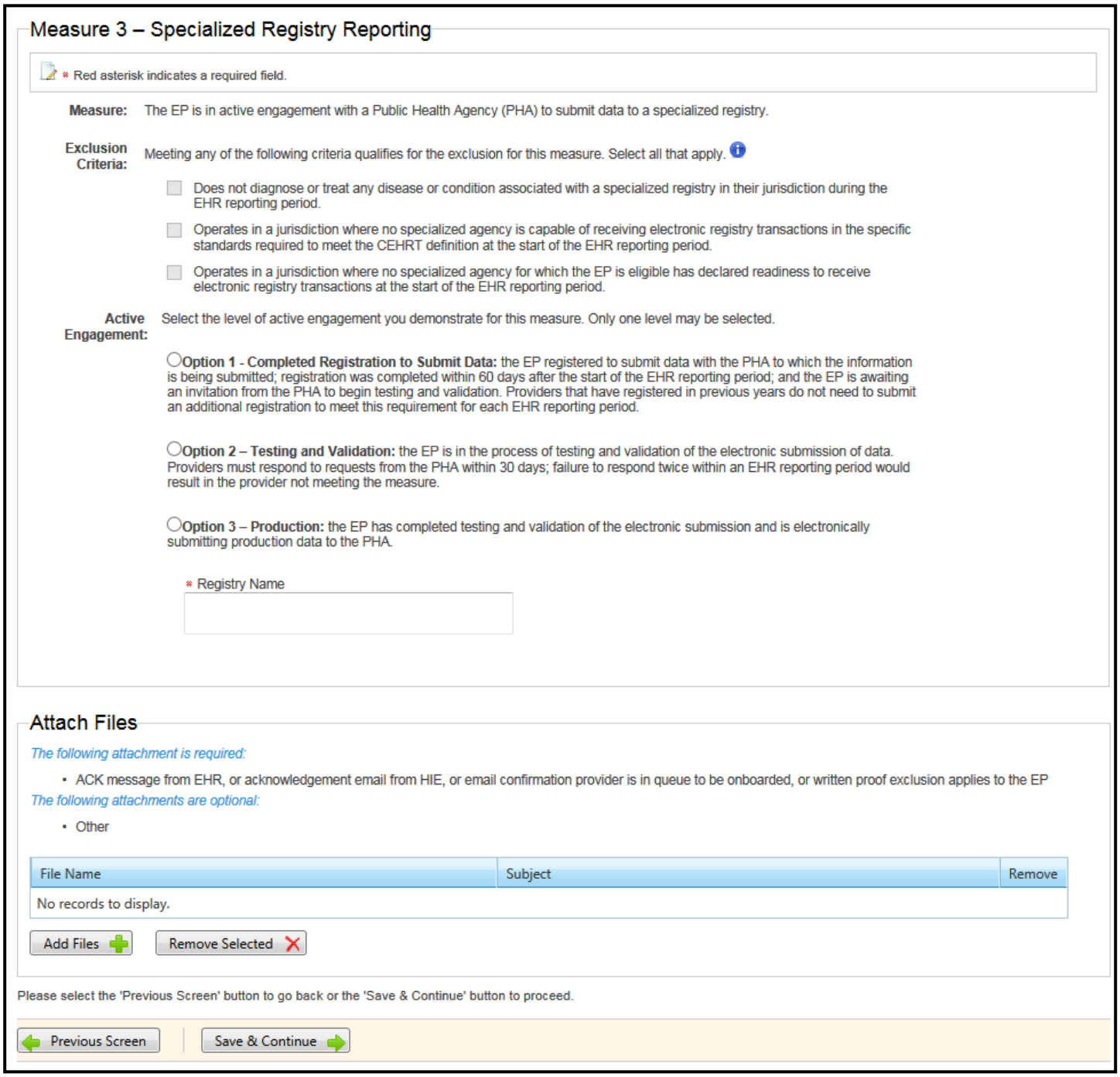
Active Engagement Option 2- Testing and Validation



Active Engagement Option 3- Production



Specialized Registry Reporting (#1 and #2)



Measure 3 – Specialized Registry Reporting

* Red asterisk indicates a required field.

Measure: The EP is in active engagement with a Public Health Agency (PHA) to submit data to a specialized registry.

Exclusion Criteria: Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.

- ☐ Does not diagnose or treat any disease or condition associated with a specialized registry in their jurisdiction during the EHR reporting period.
- ☐ Operates in a jurisdiction where no specialized agency is capable of receiving electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
- ☐ Operates in a jurisdiction where no specialized agency for which the EP is eligible has declared readiness to receive electronic registry transactions at the start of the EHR reporting period.

Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

- ○ **Option 1 - Completed Registration to Submit Data:** the EP registered to submit data with the PHA to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
- ○ **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.
- ○ **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA.

* Registry Name

Attach Files

The following attachment is required:

- ACK message from EHR, or acknowledgement email from HIE, or email confirmation provider is in queue to be onboarded, or written proof exclusion applies to the EP

The following attachments are optional:

- Other

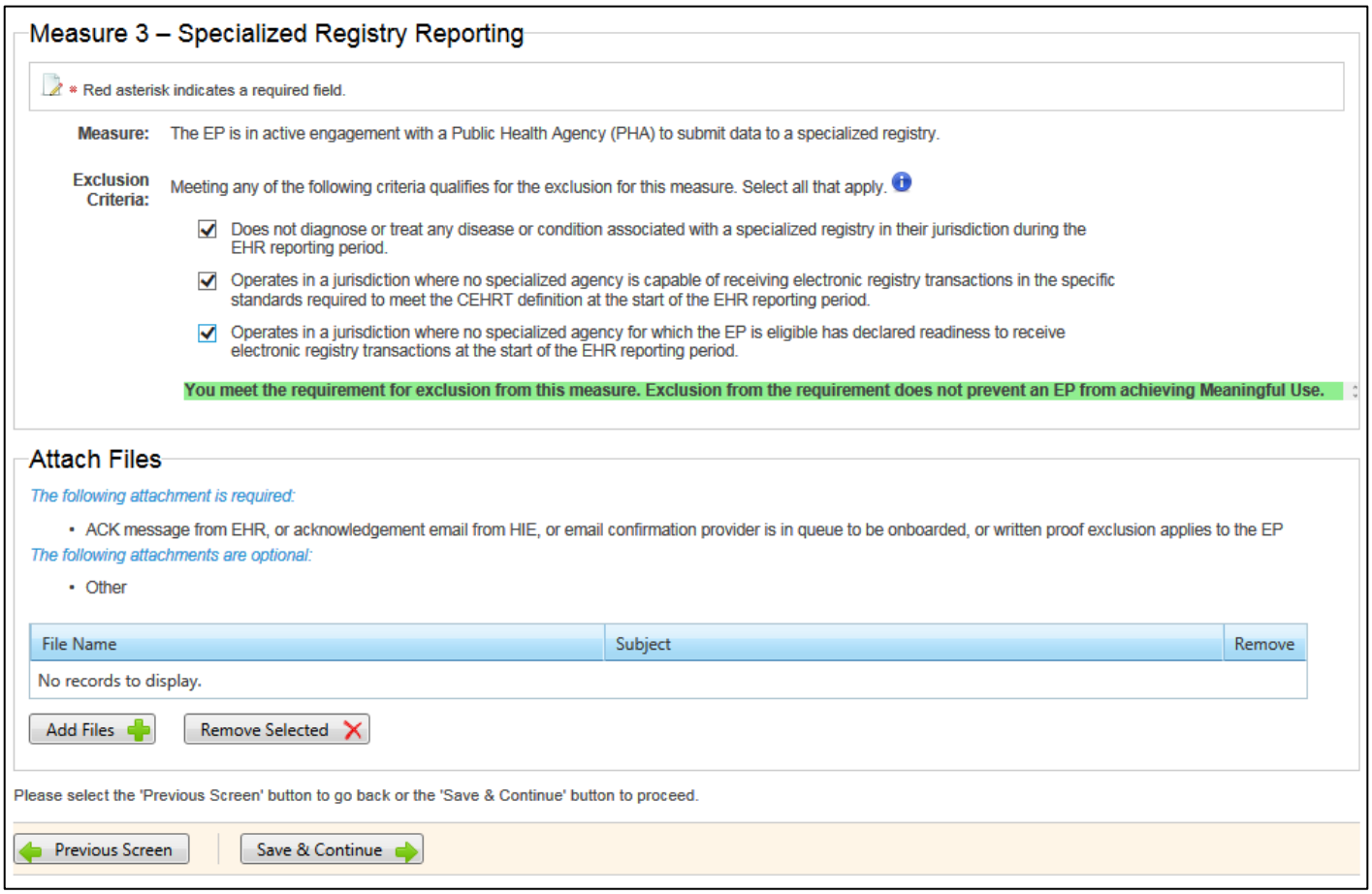
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

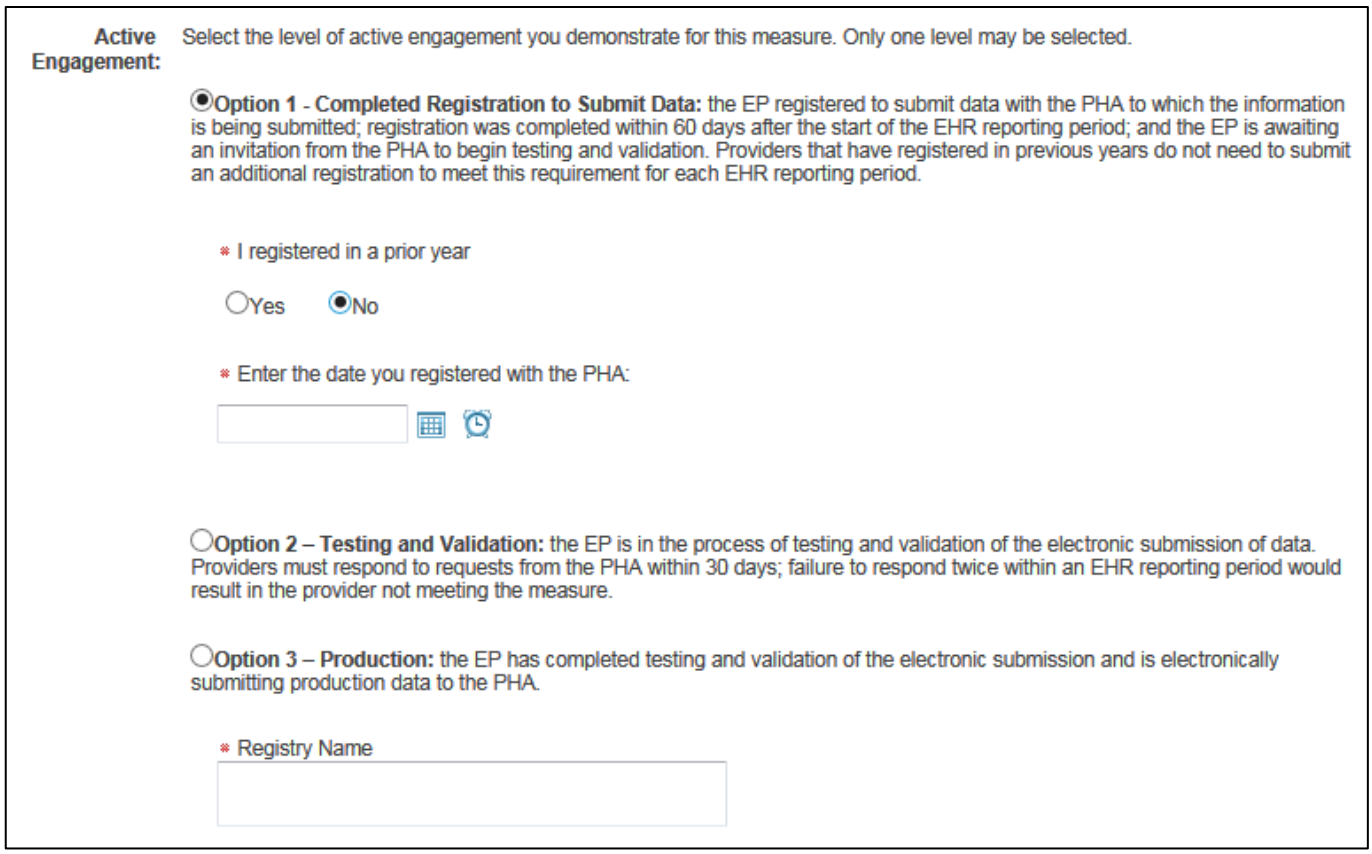
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

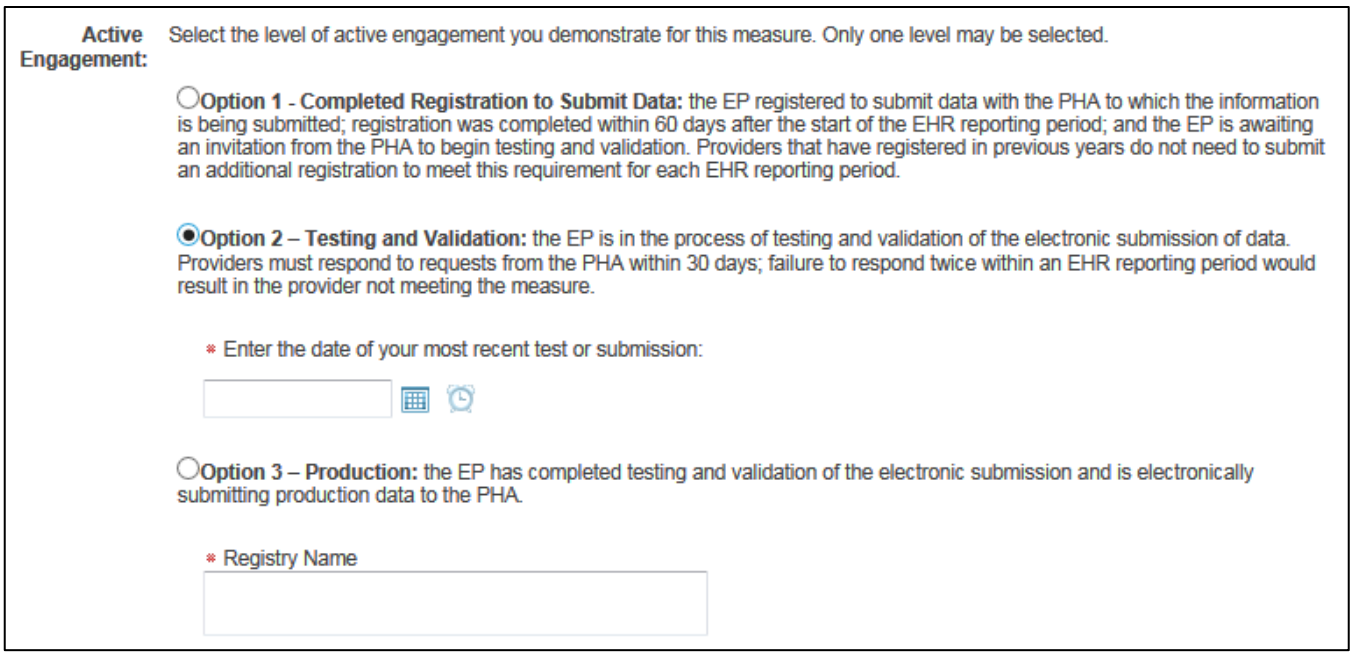
Exclusions



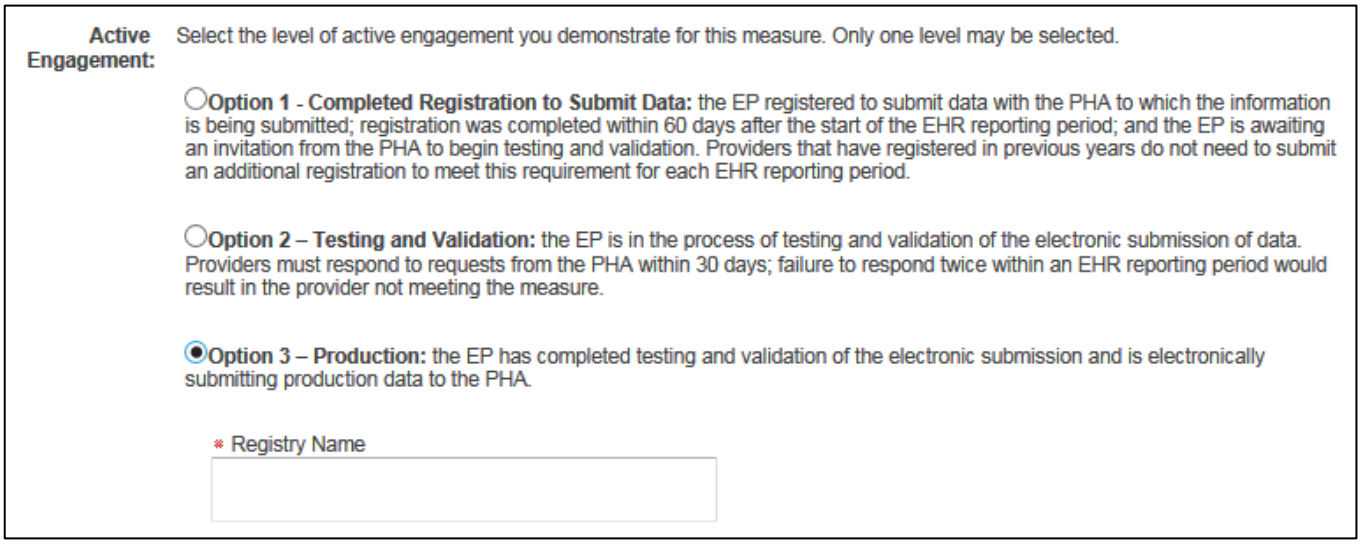
Active Engagement Option 1- Completed Registration to Submit Data



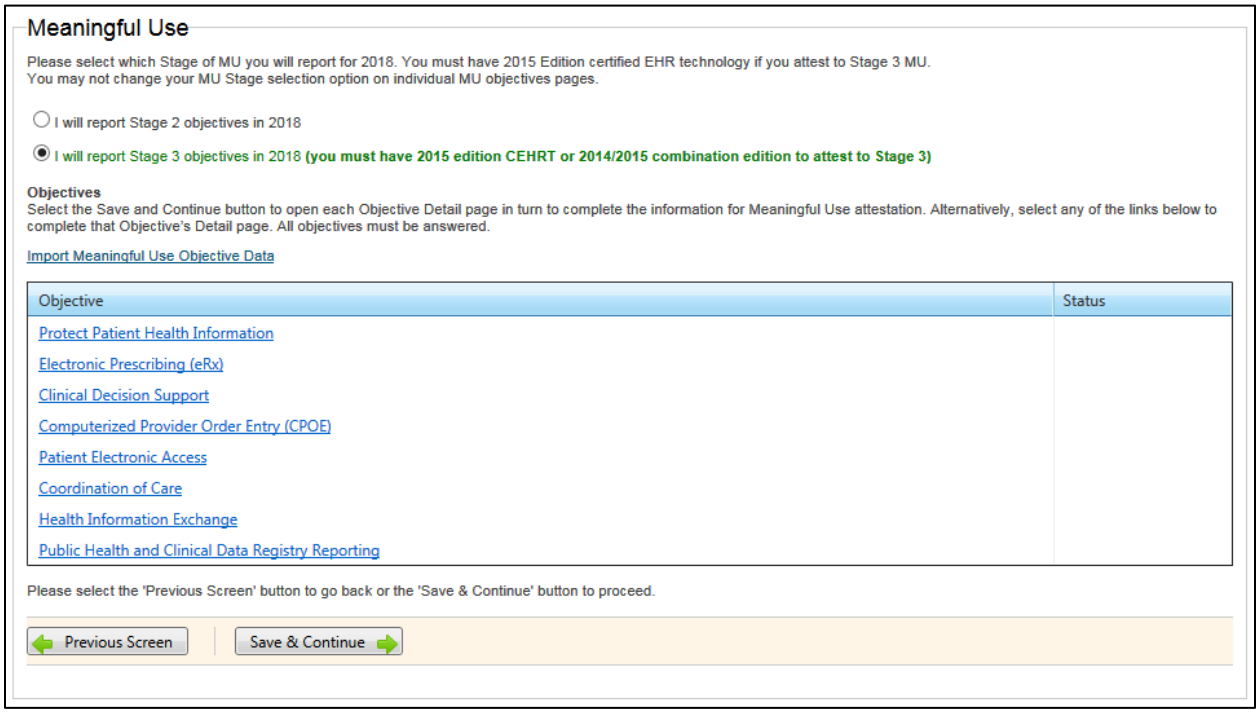
Active Engagement Option 2- Testing and Validation



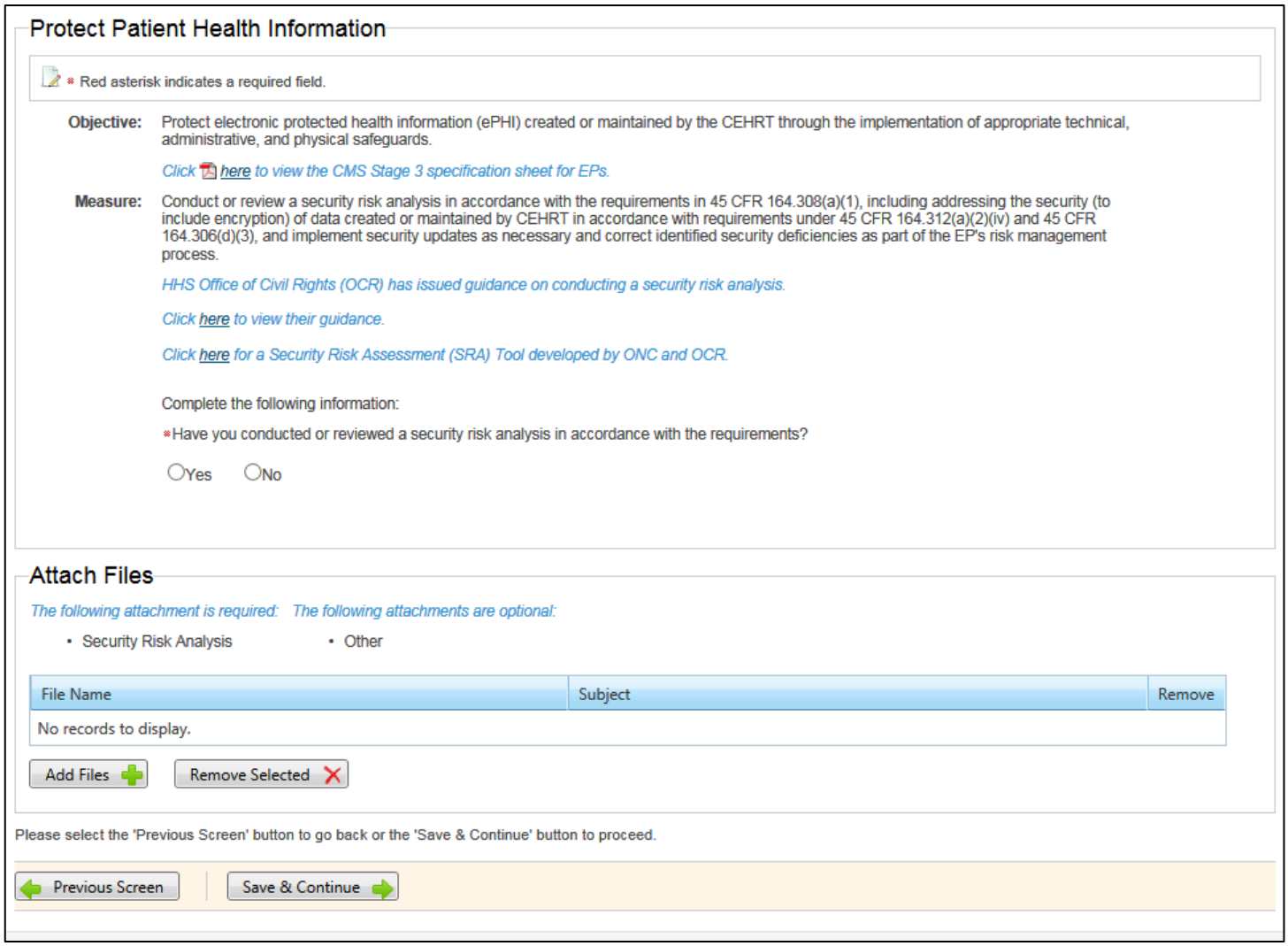
Active Engagement Option 3- Production

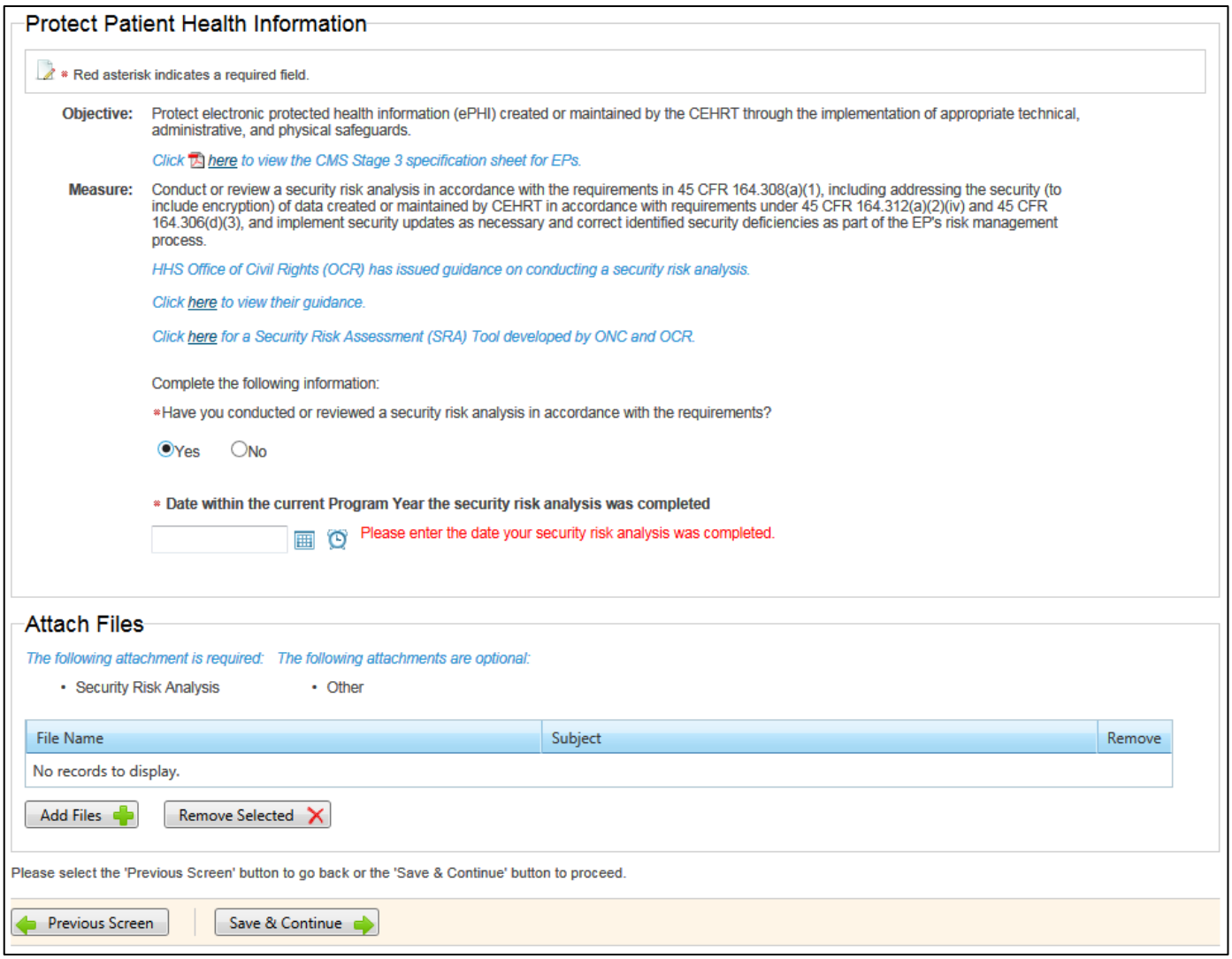


Stage 3
Meaningful Use Summary

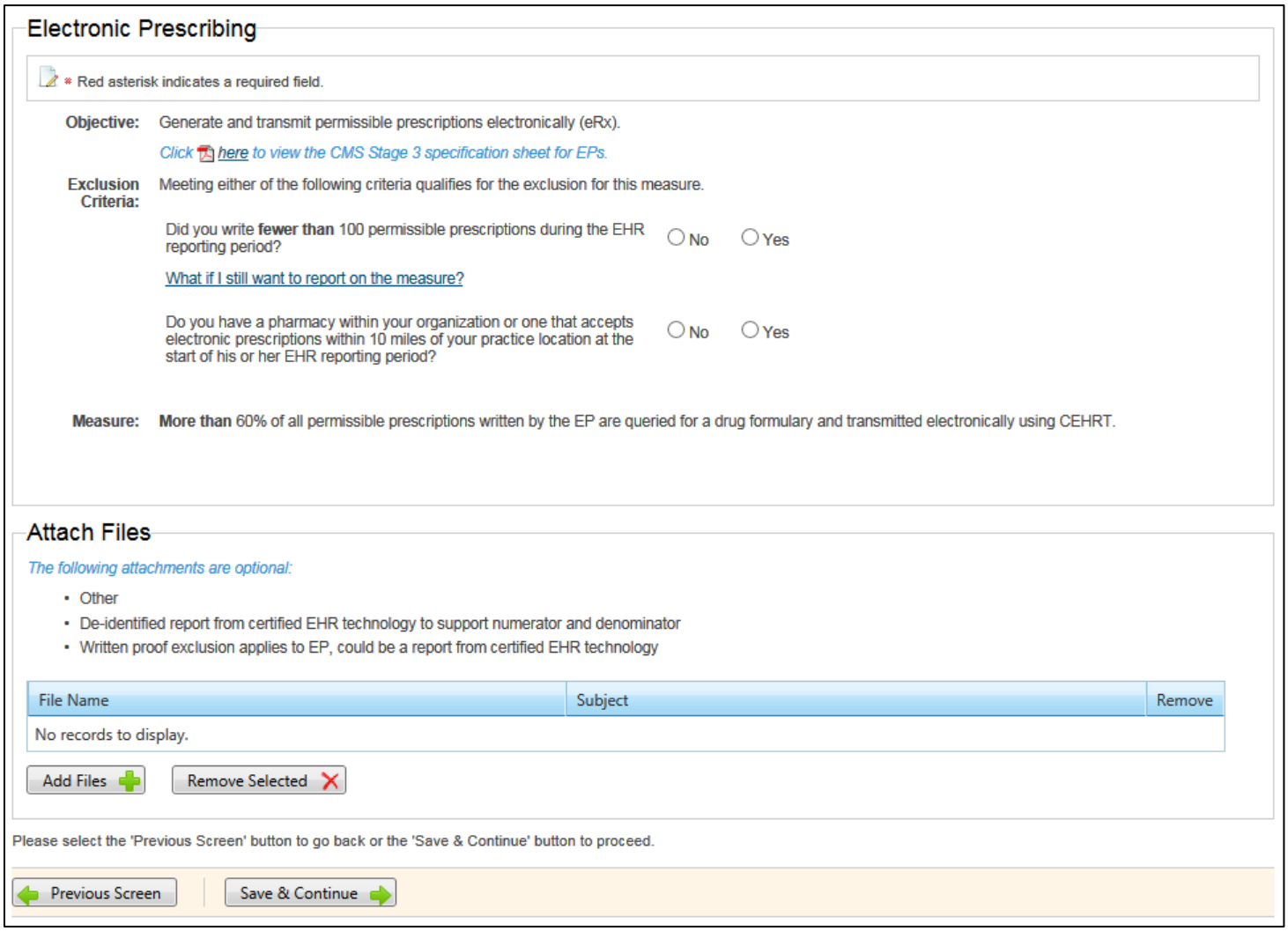


Protect Patient Health Information

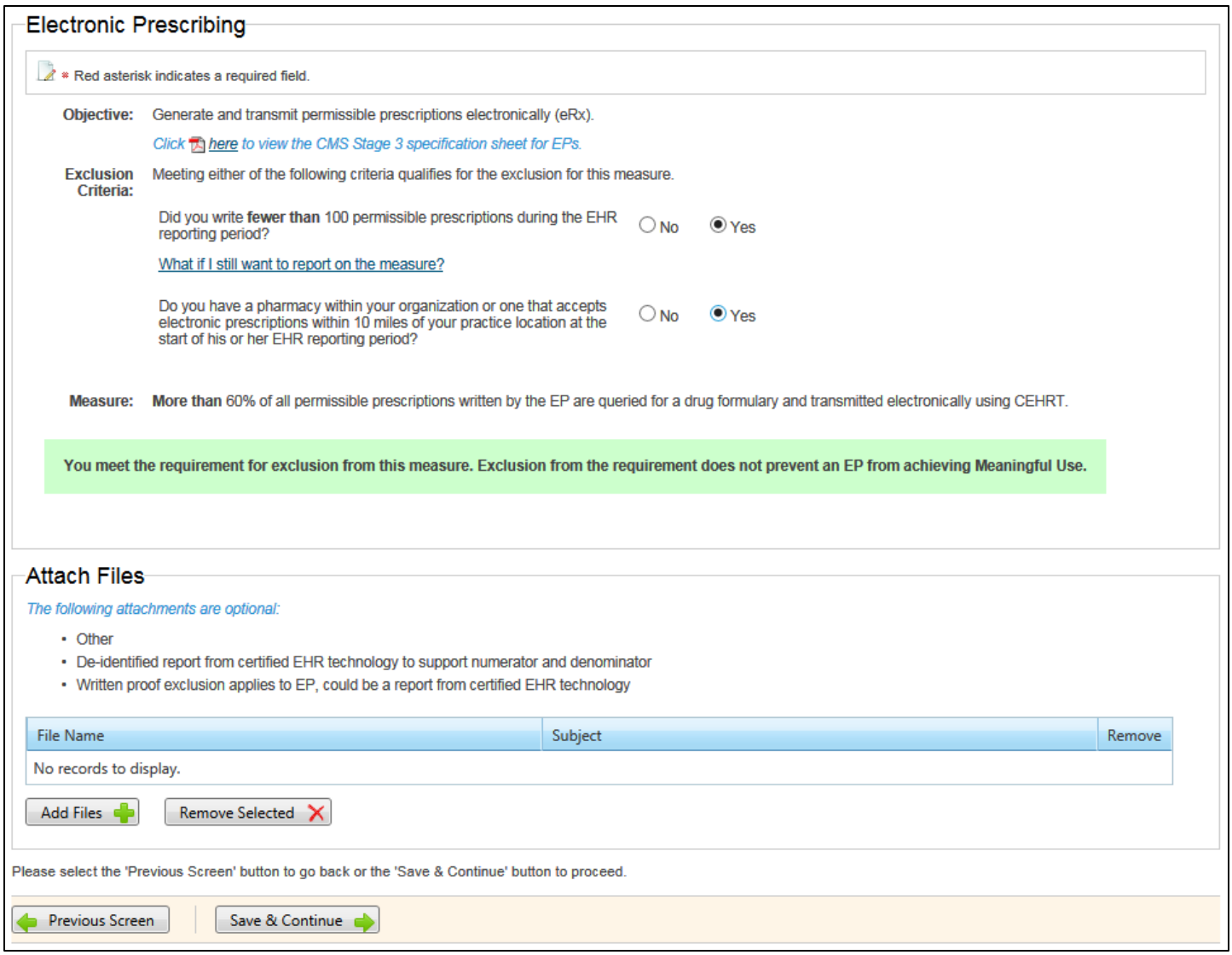


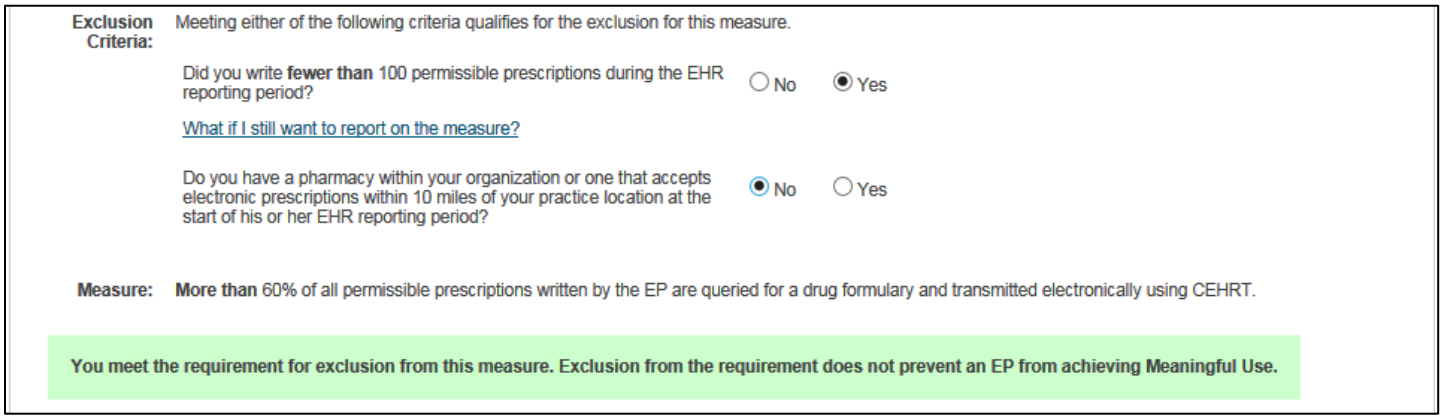

Protect Patient Health Information
* Red asterisk indicates a required field.
Objective: Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.
Click here to view the CMS Stage 3 specification sheet for EPs.
Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process.
HHS Office of Civil Rights (OCR) has issued guidance on conducting a security risk analysis.
Click here to view their guidance.
Click here for a Security Risk Assessment (SRA) Tool developed by ONC and OCR.
Complete the following information:
*Have you conducted or reviewed a security risk analysis in accordance with the requirements?
Yes
No
* Date within the current Program Year the security risk analysis was completed
Please enter the date your security risk analysis was completed.
Attach Files
The following attachment is required:
Security Risk Analysis
The following attachments are optional:
Other
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Previous Screen
Save & Continue

Electronic Prescribing



Exclusions


Electronic Prescribing
* Red asterisk indicates a required field.
Objective: Generate and transmit permissible prescriptions electronically (eRx).
Click here to view the CMS Stage 3 specification sheet for EPs.
Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.
Did you write fewer than 100 permissible prescriptions during the EHR reporting period? No Yes
What if I still want to report on the measure?
Do you have a pharmacy within your organization or one that accepts electronic prescriptions within 10 miles of your practice location at the start of his or her EHR reporting period? No Yes
Measure: More than 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Attach Files
The following attachments are optional:
Other
De-identified report from certified EHR technology to support numerator and denominator
Written proof exclusion applies to EP, could be a report from certified EHR technology
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Previous Screen
Save & Continue


Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.
Did you write fewer than 100 permissible prescriptions during the EHR reporting period? No Yes
What if I still want to report on the measure?
Do you have a pharmacy within your organization or one that accepts electronic prescriptions within 10 miles of your practice location at the start of his or her EHR reporting period? No Yes
Measure: More than 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

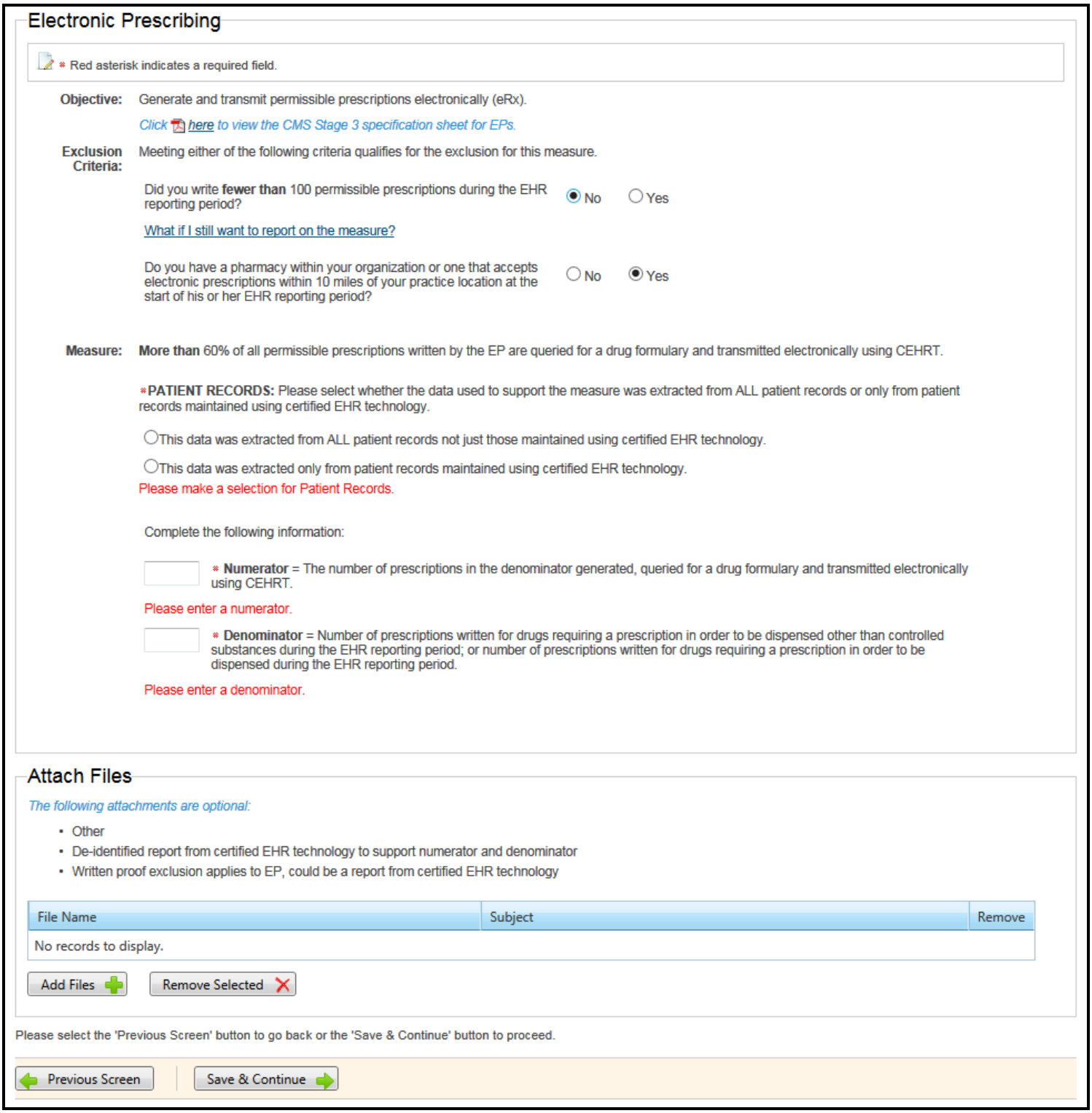
Did you write **fewer than** 100 permissible prescriptions during the EHR reporting period? ◉ No ○ Yes

What if I still want to report on the measure?

Do you have a pharmacy within your organization or one that accepts electronic prescriptions within 10 miles of your practice location at the start of his or her EHR reporting period? ◉ No ○ Yes

Measure: **More than** 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.



Electronic Prescribing

* Red asterisk indicates a required field.

Objective: Generate and transmit permissible prescriptions electronically (eRx).

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you write **fewer than** 100 permissible prescriptions during the EHR reporting period? (●) No ( ) Yes

What if I still want to report on the measure?

Do you have a pharmacy within your organization or one that accepts electronic prescriptions within 10 miles of your practice location at the start of his or her EHR reporting period? ( ) No (●) Yes

Measure: **More than** 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

( ) This data was extracted from ALL patient records not just those maintained using certified EHR technology.

( ) This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

* **Numerator** = The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.

Please enter a numerator.

* **Denominator** = Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.

Please enter a denominator.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

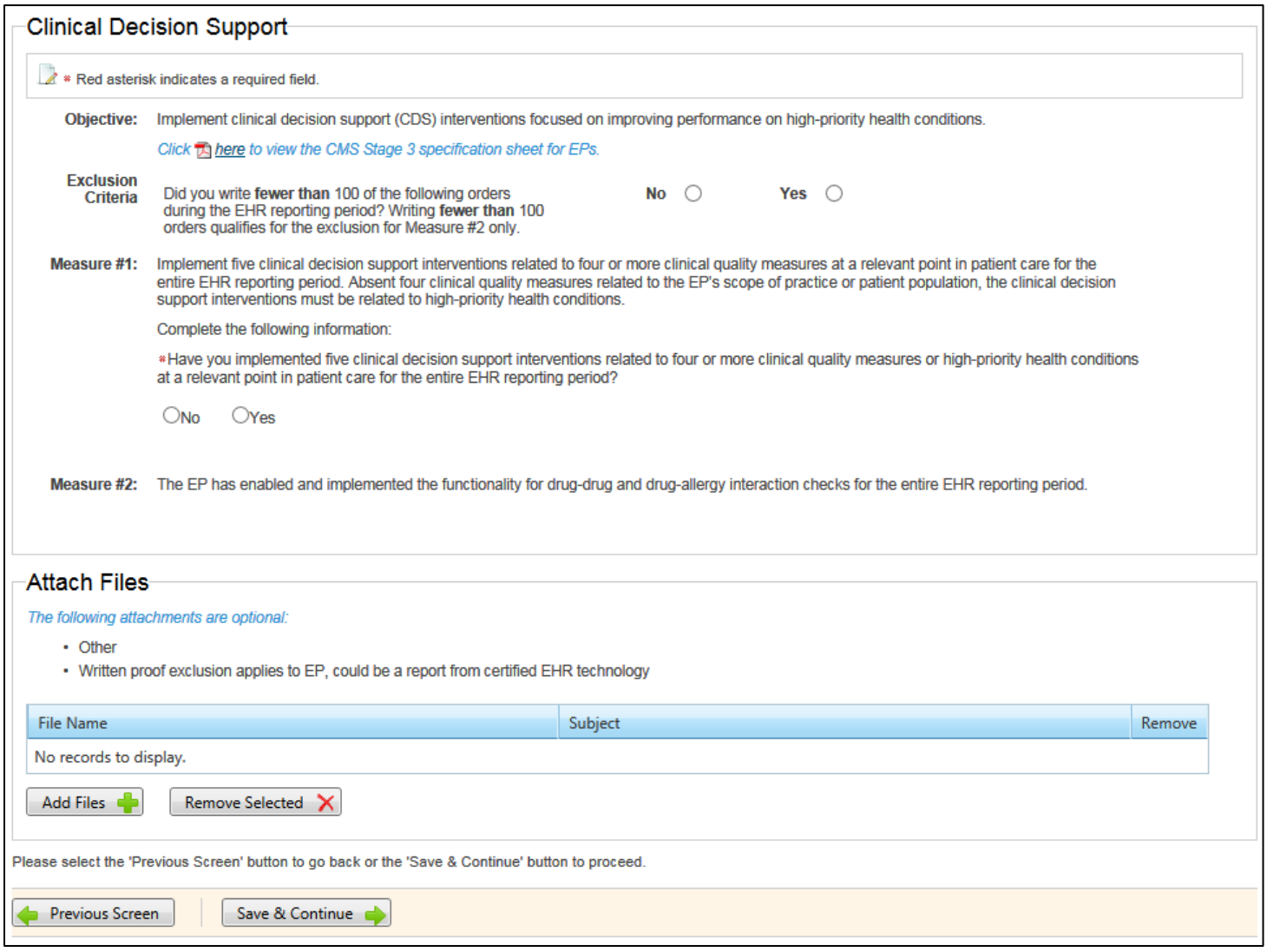
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Clinical Decision Support



Exclusion for Measure #2

Clinical Decision Support

* Red asterisk indicates a required field.

Objective: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria

Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for Measure #2 only.

No ○ **Yes** ◉

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

○No ○Yes

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Attach Files

The following attachments are optional:

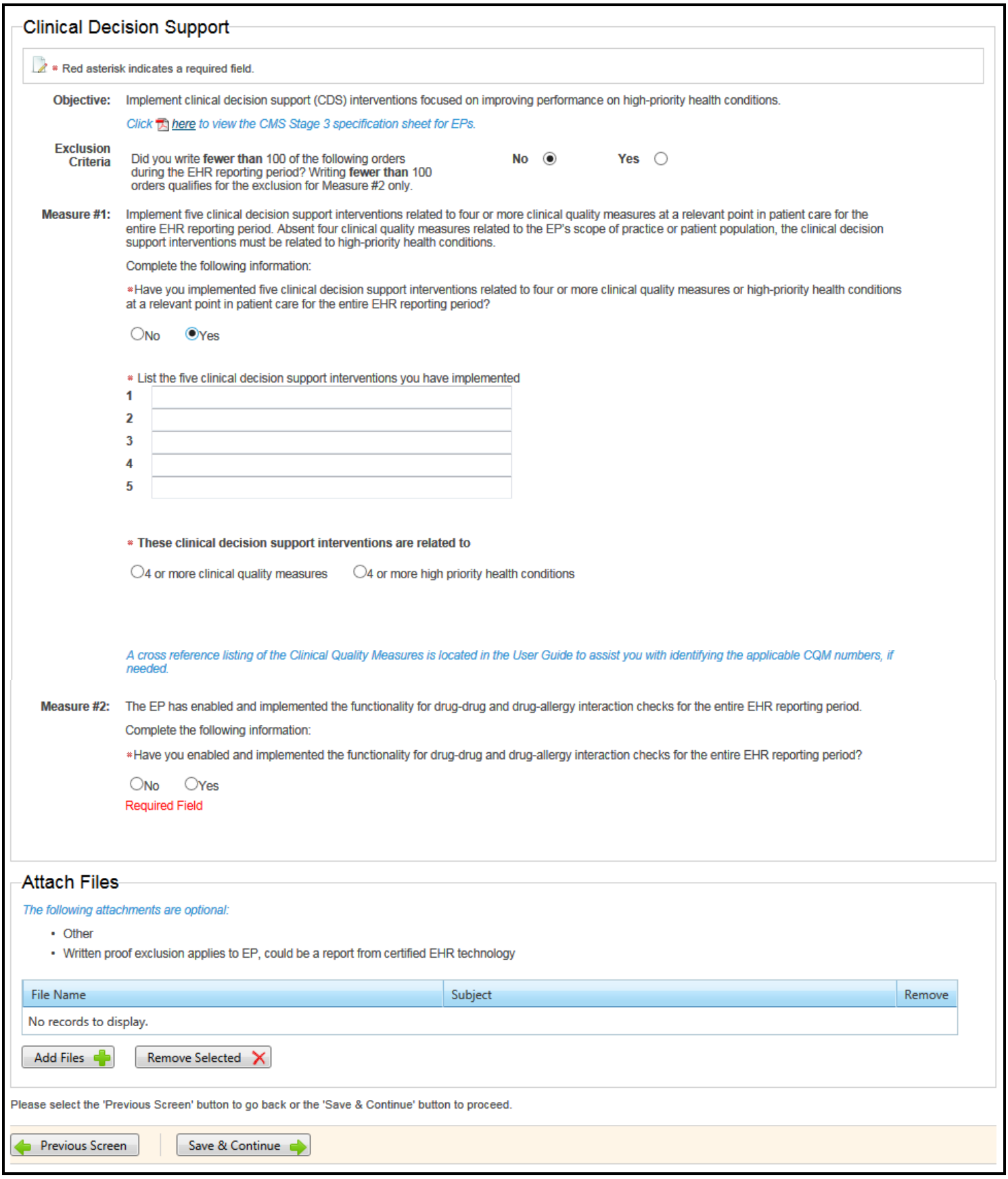
- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue



Clinical Decision Support

* Red asterisk indicates a required field.

Objective: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for Measure #2 only. **No** ◉ **Yes** ○

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

○No ◉Yes

* List the five clinical decision support interventions you have implemented

1
2
3
4
5

* **These clinical decision support interventions are related to**

○4 or more clinical quality measures ○4 or more high priority health conditions

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Complete the following information:

*Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

○No ○Yes

Required Field

Attach Files

The following attachments are optional:

- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen Save & Continue

4 or more Clinical Quality Measures

Clinical Decision Support

* Red asterisk indicates a required field.

Objective: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria

Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for Measure #2 only.

No (●) **Yes** ( )

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

( ) No (●) Yes

* List the five clinical decision support interventions you have implemented

1
2
3
4
5

* **These clinical decision support interventions are related to**

(●) 4 or more clinical quality measures ( ) 4 or more high priority health conditions

* **Select CQMs**

CMS52
CMS75
CMS133
CMS158

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Complete the following information:

*Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

( ) No ( ) Yes

Required Field

Attach Files

The following attachments are optional:

- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

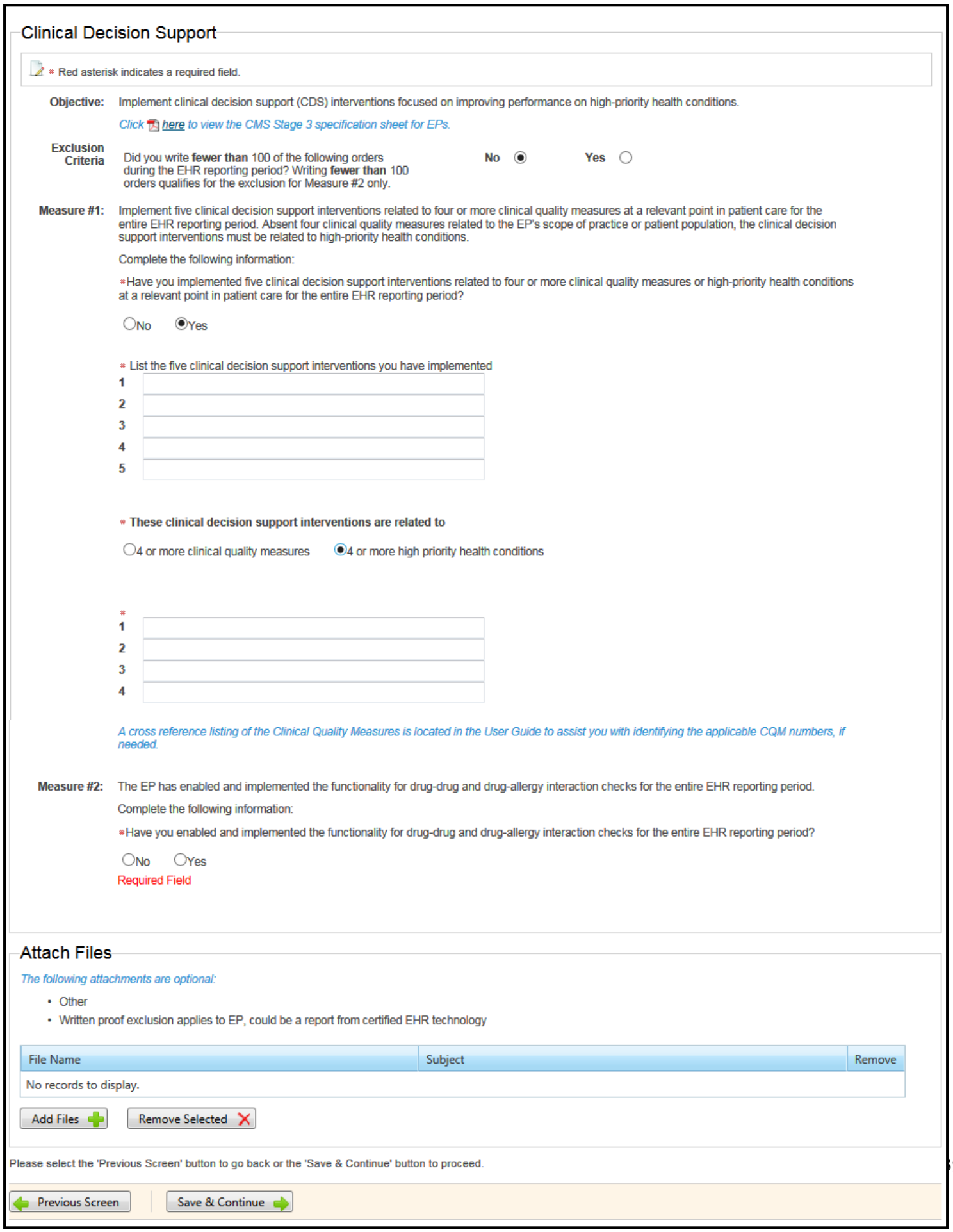
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

4 or more High Priority Health Conditions



Clinical Decision Support

* Red asterisk indicates a required field.

Objective: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria

Did you write **fewer than** 100 of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for Measure #2 only.

No (●) **Yes** ( )

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

( )No (●)Yes

* List the five clinical decision support interventions you have implemented

1
2
3
4
5

* **These clinical decision support interventions are related to**

( )4 or more clinical quality measures (●)4 or more high priority health conditions

*
1
2
3
4

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Complete the following information:

*Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

( )No ( )Yes

Required Field

Attach Files

The following attachments are optional:

- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

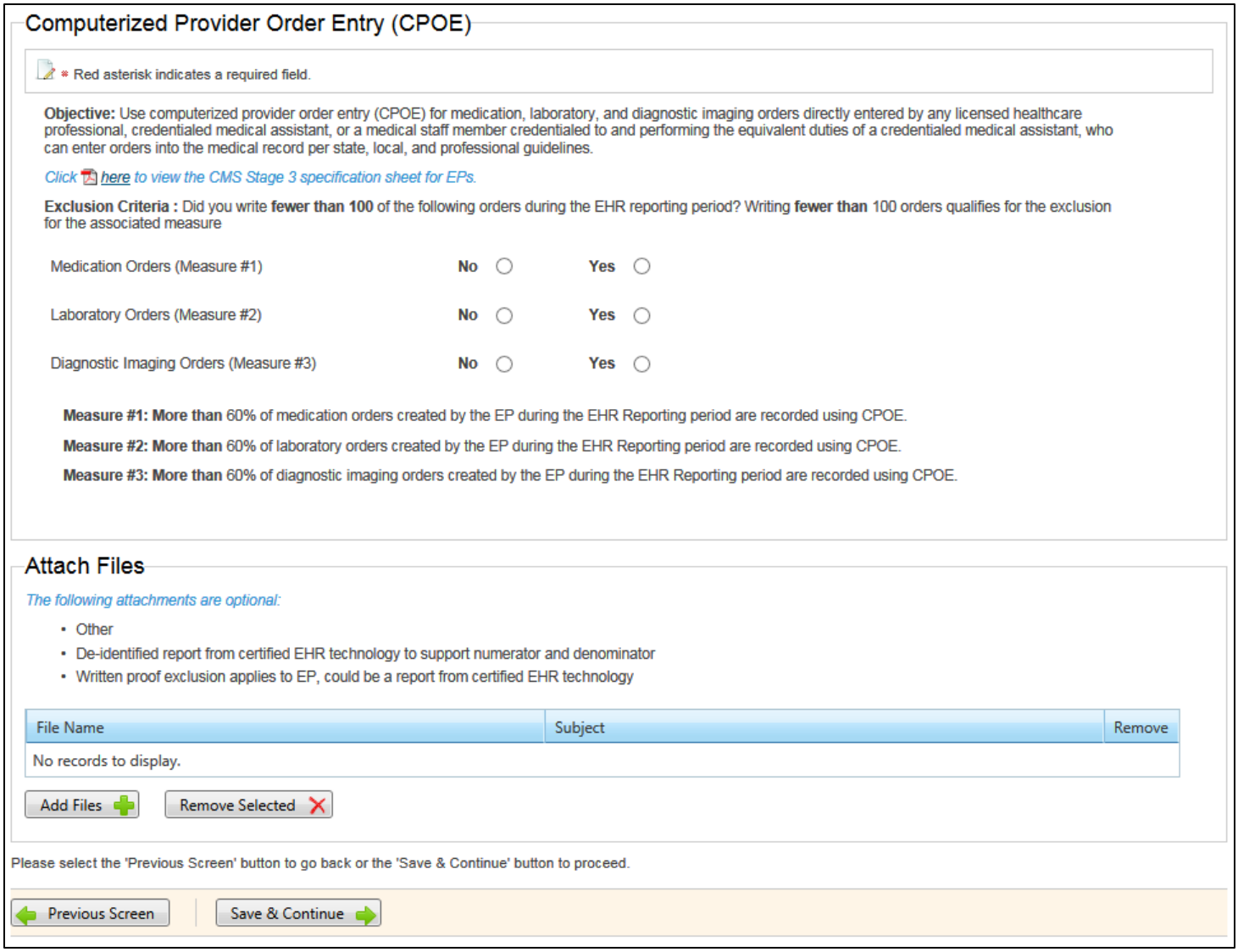
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

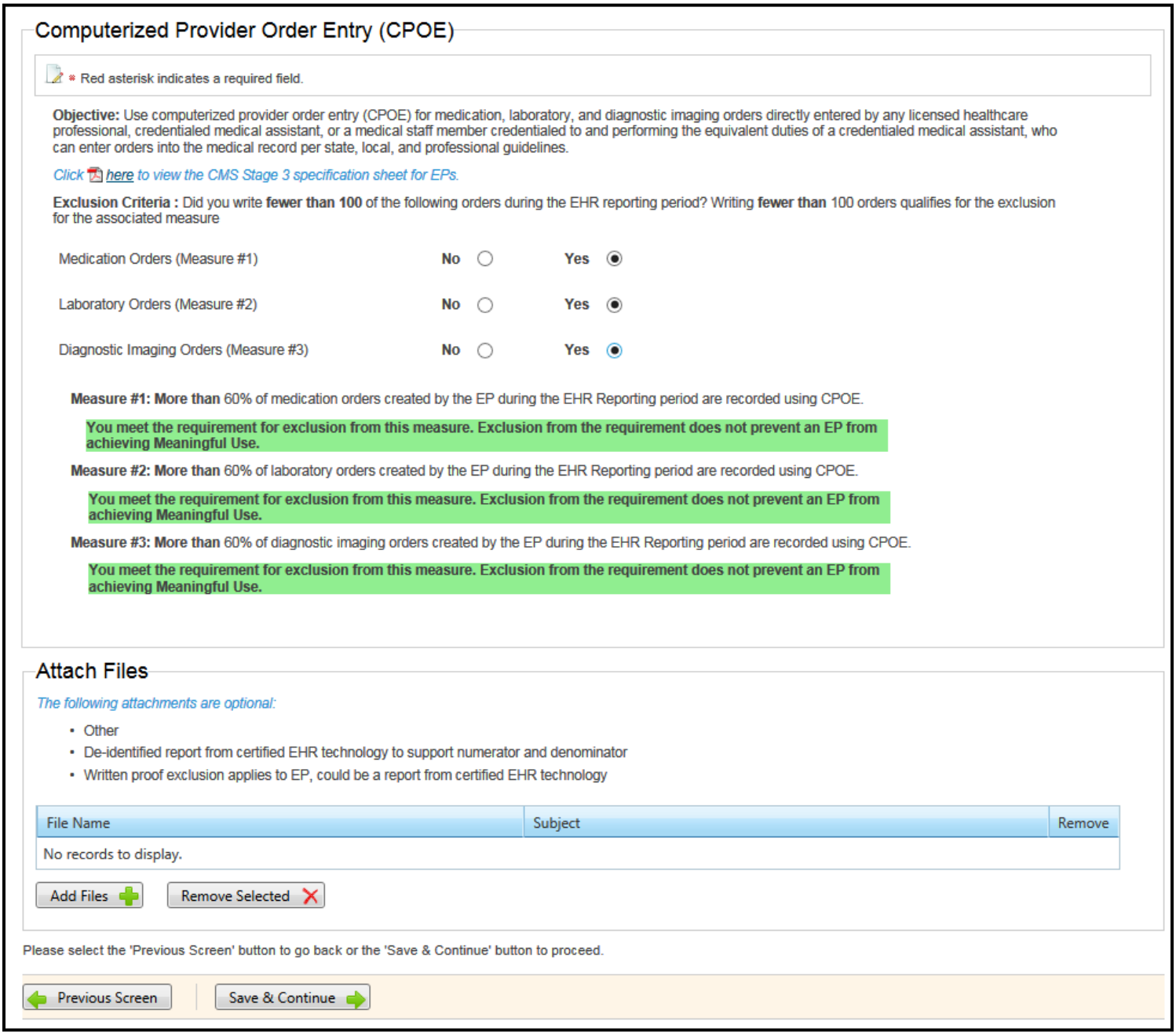
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Computerized Provider Order Entry (CPOE)



Exclusions


Computerized Provider Order Entry (CPOE)
* Red asterisk indicates a required field.
Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
Click here to view the CMS Stage 3 specification sheet for EPs.
Exclusion Criteria : Did you write fewer than 100 of the following orders during the EHR reporting period? Writing fewer than 100 orders qualifies for the exclusion for the associated measure
Medication Orders (Measure #1) No Yes
Laboratory Orders (Measure #2) No Yes
Diagnostic Imaging Orders (Measure #3) No Yes
Measure #1: More than 60% of medication orders created by the EP during the EHR Reporting period are recorded using CPOE.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Measure #2: More than 60% of laboratory orders created by the EP during the EHR Reporting period are recorded using CPOE.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Measure #3: More than 60% of diagnostic imaging orders created by the EP during the EHR Reporting period are recorded using CPOE.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Attach Files
The following attachments are optional:
Other
De-identified report from certified EHR technology to support numerator and denominator
Written proof exclusion applies to EP, could be a report from certified EHR technology
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Previous Screen
Save & Continue

Computerized Provider Order Entry (CPOE)

* Red asterisk indicates a required field.

Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria : Did you write **fewer than 100** of the following orders during the EHR reporting period? Writing **fewer than** 100 orders qualifies for the exclusion for the associated measure

Medication Orders (Measure #1)	**No** ◉	**Yes** ○
Laboratory Orders (Measure #2)	**No** ◉	**Yes** ○
Diagnostic Imaging Orders (Measure #3)	**No** ◉	**Yes** ○

Measure #1: More than 60% of medication orders created by the EP during the EHR Reporting period are recorded using CPOE.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

○ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

○ This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

* [ ] **Numerator** = The number of orders in the denominator recorded using CPOE.
Please enter a numerator.

* [ ] **Denominator** = Number of medication orders created by the EP during the EHR reporting period.
Please enter a denominator.

Measure #2: More than 60% of laboratory orders created by the EP during the EHR Reporting period are recorded using CPOE.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

○ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

○ This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Measure #3: More than 60% of diagnostic imaging orders created by the EP during the EHR Reporting period are recorded using CPOE.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

○ This data was extracted from ALL patient records not just those maintained using certified EHR technology.

○ This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

* [ ] **Numerator** = The number of orders in the denominator recorded using CPOE.
Please enter a numerator.

* [ ] **Denominator** = Number of diagnostic orders created by the EP during the EHR reporting period.
Please enter a denominator.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

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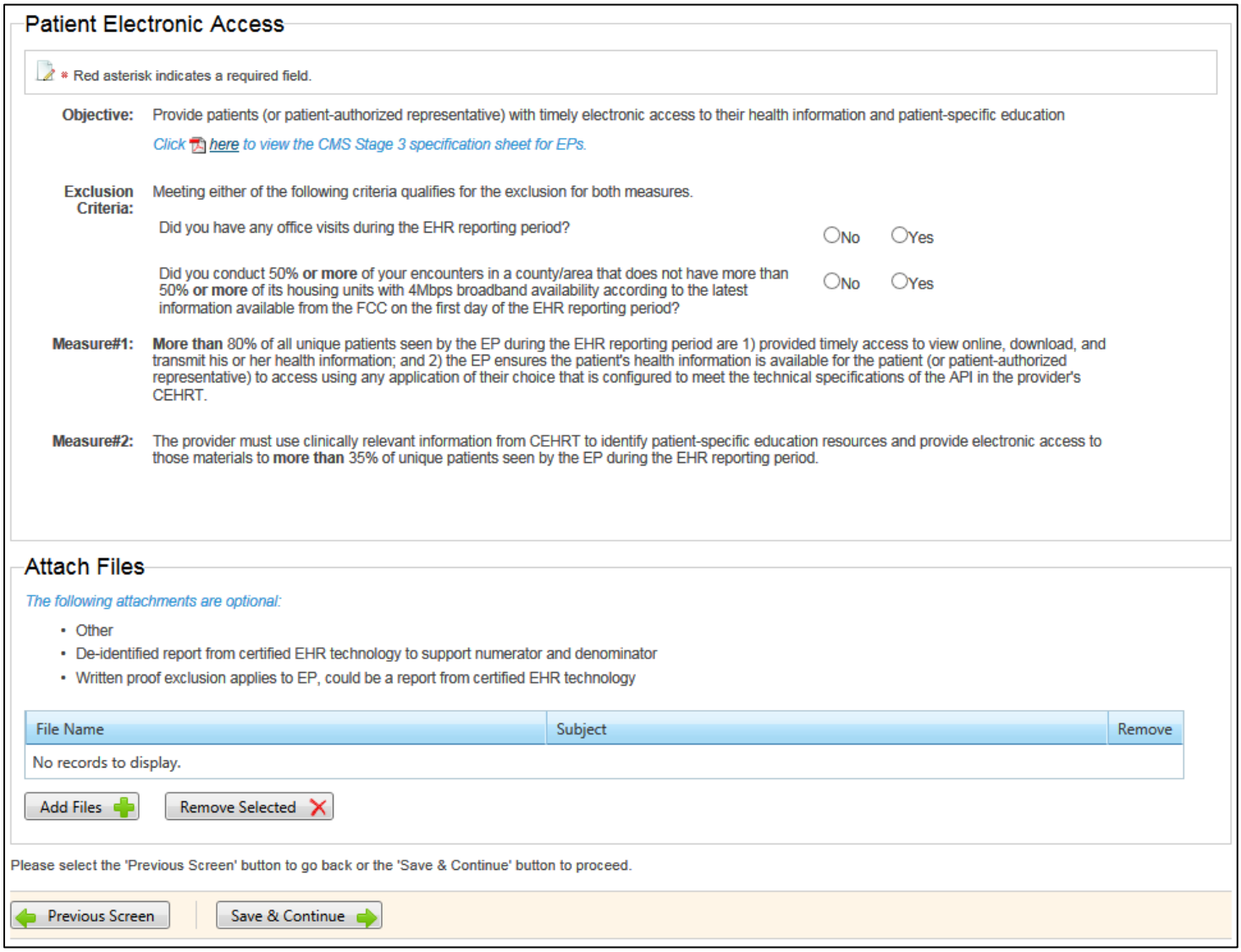
Patient Electronic Access



Patient Electronic Access

* Red asterisk indicates a required field.

Objective: Provide patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for both measures.

Did you have any office visits during the EHR reporting period? ○No ○Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? ○No ○Yes

Measure#1: **More than** 80% of all unique patients seen by the EP during the EHR reporting period are 1) provided timely access to view online, download, and transmit his or her health information; and 2) the EP ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.

Measure#2: The provider must use clinically relevant information from CEHRT to identify patient-specific education resources and provide electronic access to those materials to **more than** 35% of unique patients seen by the EP during the EHR reporting period.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

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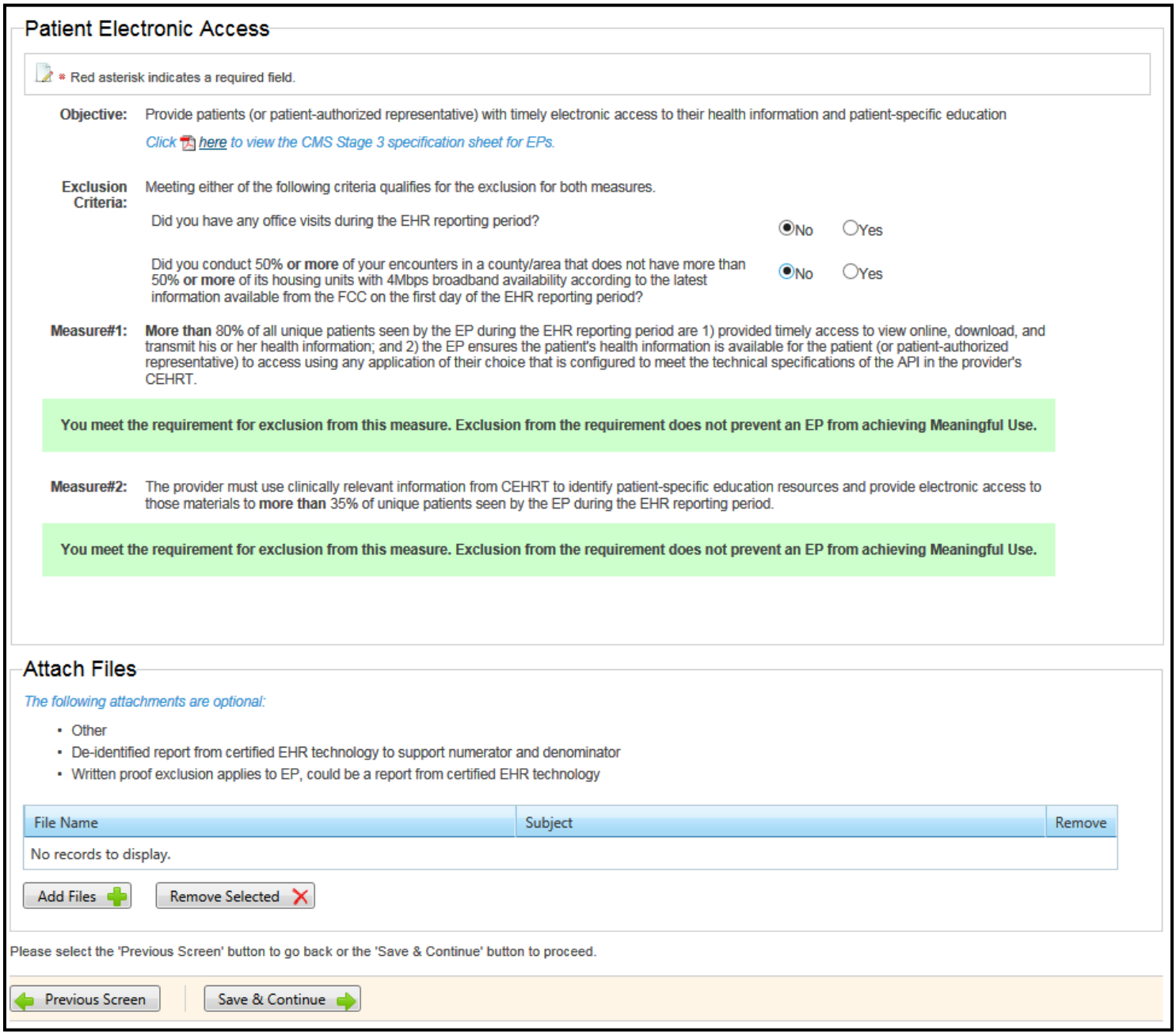
Exclusions


Patient Electronic Access
* Red asterisk indicates a required field.
Objective: Provide patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education
Click here to view the CMS Stage 3 specification sheet for EPs.
Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for both measures.
Did you have any office visits during the EHR reporting period? No Yes
Did you conduct 50% or more of your encounters in a county/area that does not have more than 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? No Yes
Measure#1: More than 80% of all unique patients seen by the EP during the EHR reporting period are 1) provided timely access to view online, download, and transmit his or her health information; and 2) the EP ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Measure#2: The provider must use clinically relevant information from CEHRT to identify patient-specific education resources and provide electronic access to those materials to more than 35% of unique patients seen by the EP during the EHR reporting period.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Attach Files
The following attachments are optional:
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Written proof exclusion applies to EP, could be a report from certified EHR technology
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Previous Screen
Save & Continue

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for both measures.

Did you have any office visits during the EHR reporting period?	◉No	○Yes
Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period?	○No	◉Yes

Measure#1: **More than** 80% of all unique patients seen by the EP during the EHR reporting period are 1) provided timely access to view online, download, and transmit his or her health information; and 2) the EP ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#2: The provider must use clinically relevant information from CEHRT to identify patient-specific education resources and provide electronic access to those materials to **more than** 35% of unique patients seen by the EP during the EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for both measures.

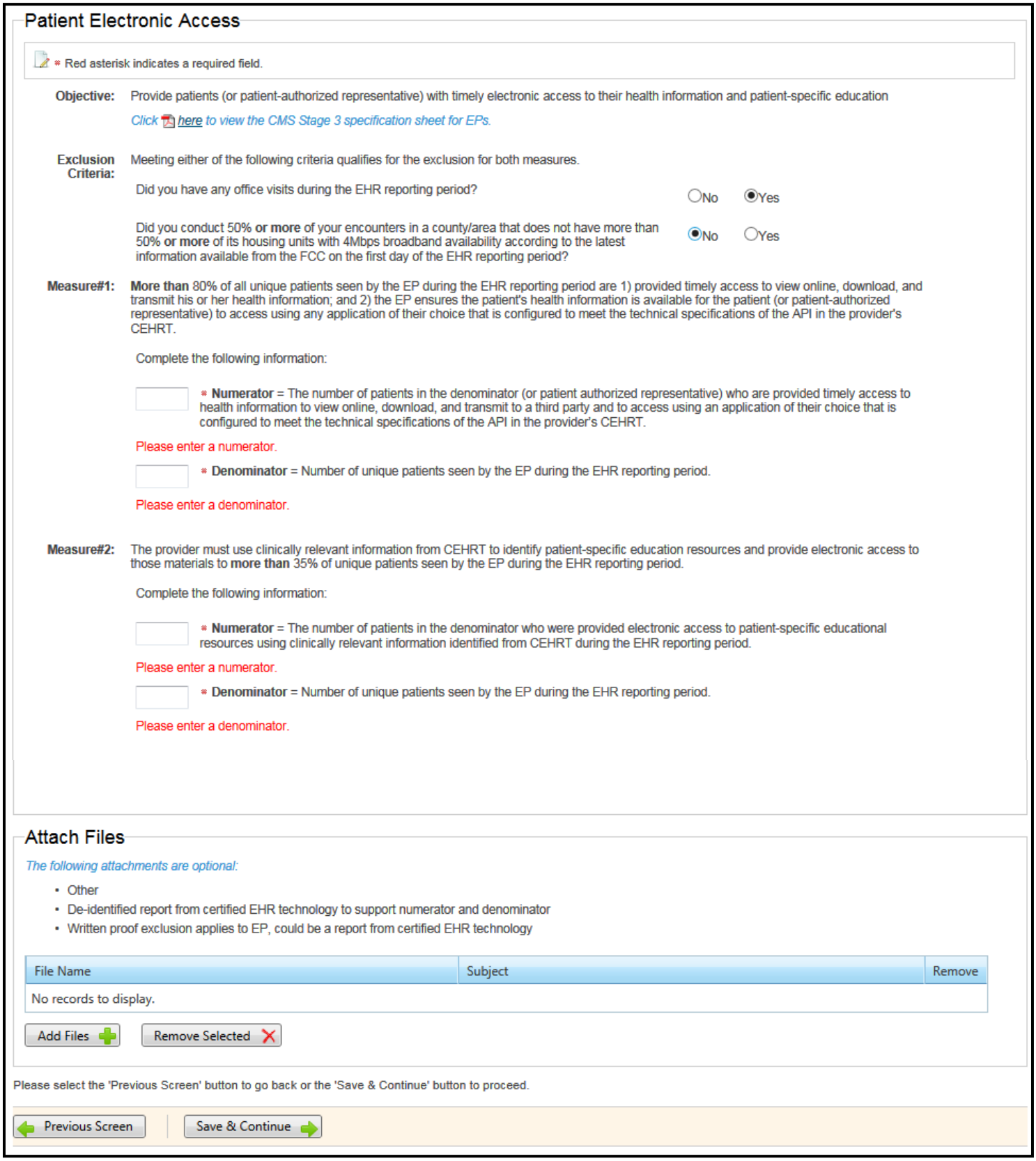
Did you have any office visits during the EHR reporting period?	○No	◉Yes
Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period?	○No	◉Yes

Measure#1: **More than** 80% of all unique patients seen by the EP during the EHR reporting period are 1) provided timely access to view online, download, and transmit his or her health information; and 2) the EP ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#2: The provider must use clinically relevant information from CEHRT to identify patient-specific education resources and provide electronic access to those materials to **more than** 35% of unique patients seen by the EP during the EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.



Patient Electronic Access

* Red asterisk indicates a required field.

Objective: Provide patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for both measures.

Did you have any office visits during the EHR reporting period? ○No ◉Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? ◉No ○Yes

Measure#1: **More than** 80% of all unique patients seen by the EP during the EHR reporting period are 1) provided timely access to view online, download, and transmit his or her health information; and 2) the EP ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.

Complete the following information:

* **Numerator** = The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.

Please enter a numerator.

* **Denominator** = Number of unique patients seen by the EP during the EHR reporting period.

Please enter a denominator.

Measure#2: The provider must use clinically relevant information from CEHRT to identify patient-specific education resources and provide electronic access to those materials to **more than** 35% of unique patients seen by the EP during the EHR reporting period.

Complete the following information:

* **Numerator** = The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the EHR reporting period.

Please enter a numerator.

* **Denominator** = Number of unique patients seen by the EP during the EHR reporting period.

Please enter a denominator.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

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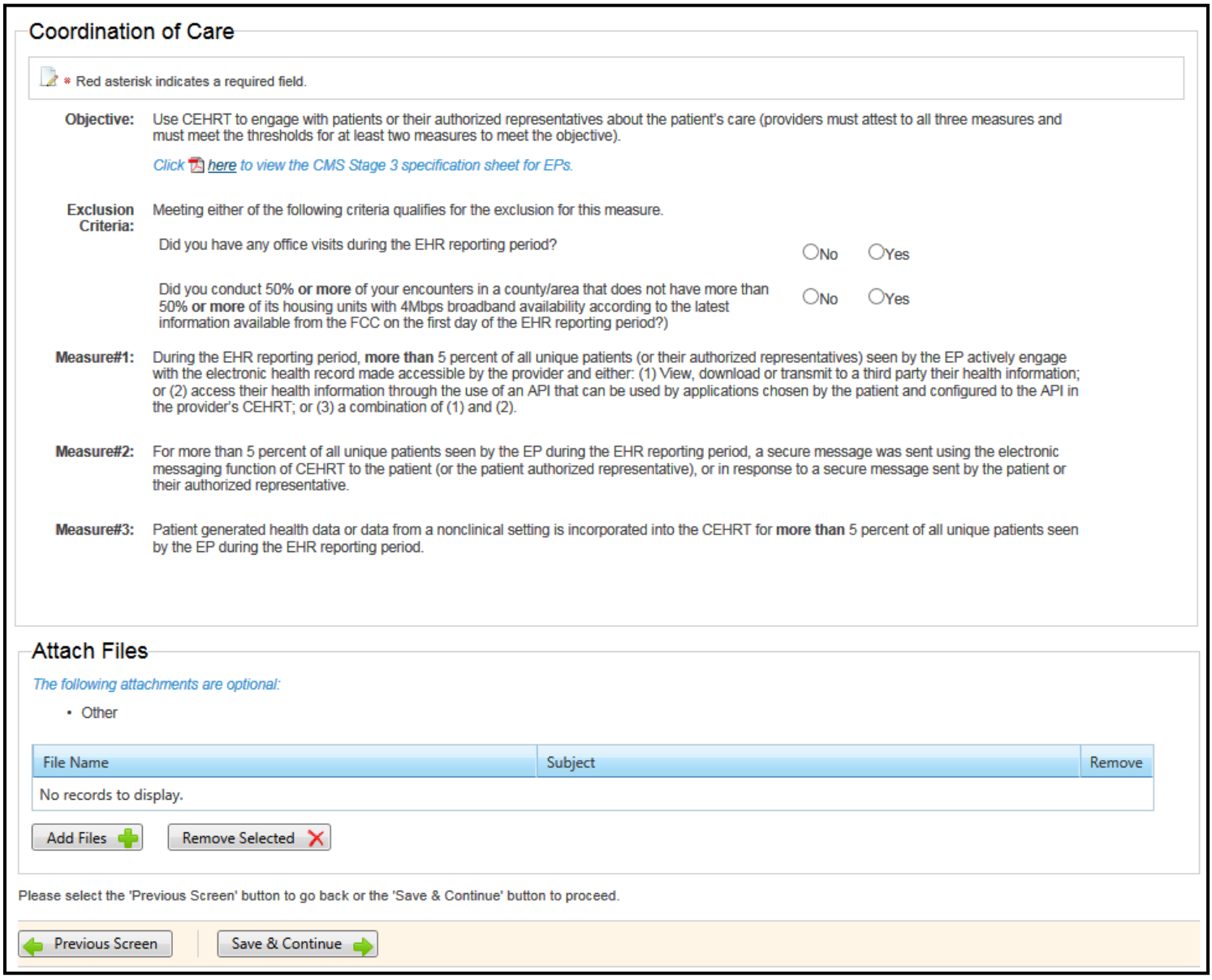
Coordination of Care



Coordination of Care

* Red asterisk indicates a required field.

Objective: Use CEHRT to engage with patients or their authorized representatives about the patient's care (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have any office visits during the EHR reporting period? ○No ○Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period?) ○No ○Yes

Measure#1: During the EHR reporting period, **more than** 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).

Measure#2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Measure#3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for **more than** 5 percent of all unique patients seen by the EP during the EHR reporting period.

Attach Files

The following attachments are optional:

- Other

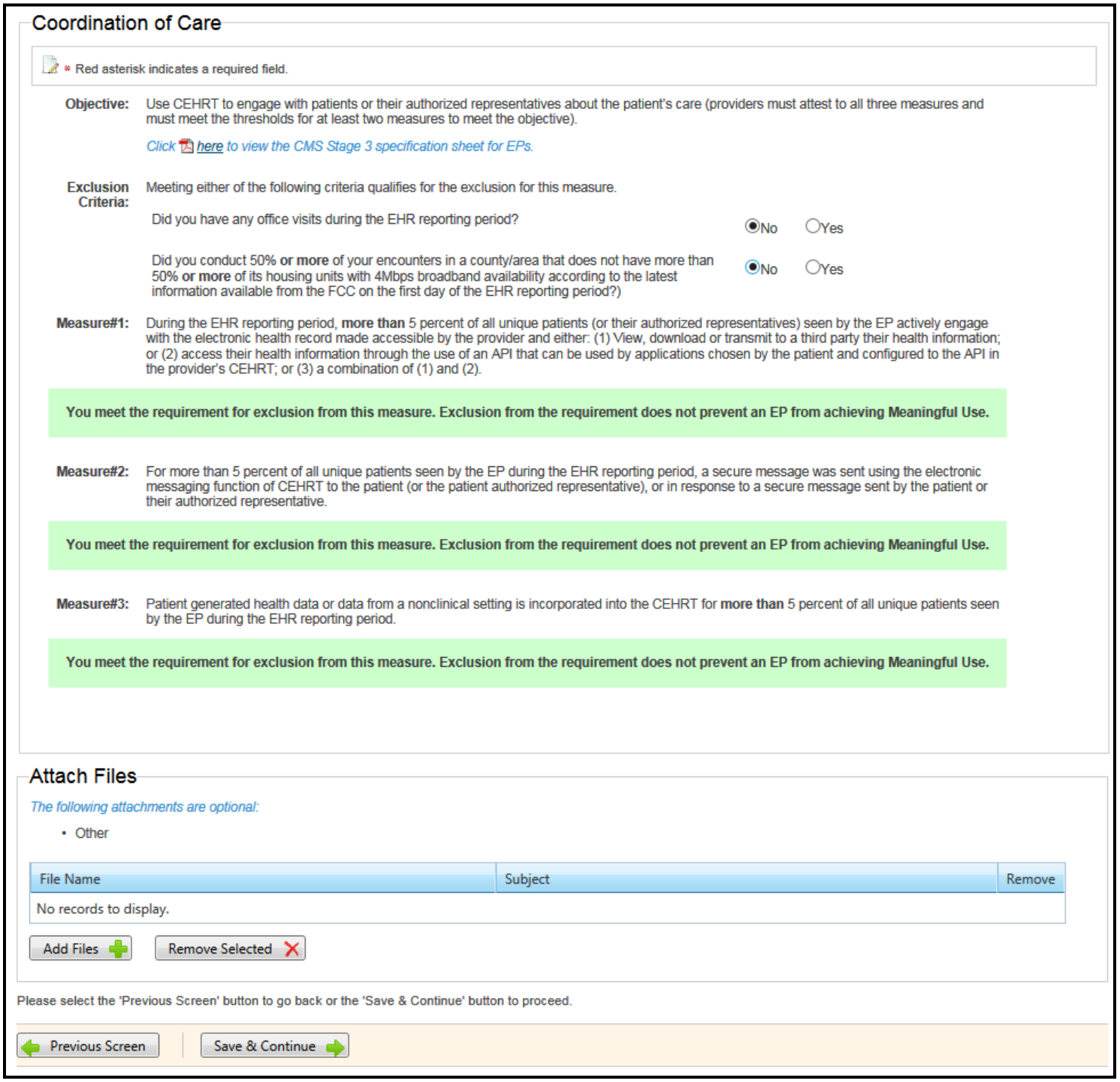
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Exclusions



Coordination of Care

* Red asterisk indicates a required field.

Objective: Use CEHRT to engage with patients or their authorized representatives about the patient's care (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have any office visits during the EHR reporting period? (●) No ( ) Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period?) (●) No ( ) Yes

Measure#1: During the EHR reporting period, **more than** 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for **more than** 5 percent of all unique patients seen by the EP during the EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Attach Files

The following attachments are optional:

- Other

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have any office visits during the EHR reporting period?	◉No	○Yes
Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period?)	○No	◉Yes

Measure#1: During the EHR reporting period, **more than** 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for **more than** 5 percent of all unique patients seen by the EP during the EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have any office visits during the EHR reporting period?	○No	◉Yes
Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period?)	○No	◉Yes

Measure#1: During the EHR reporting period, **more than** 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for **more than** 5 percent of all unique patients seen by the EP during the EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Reporting on the Measures

Coordination of Care

* Red asterisk indicates a required field.

Objective: Use CEHRT to engage with patients or their authorized representatives about the patient's care (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have any office visits during the EHR reporting period? ○No ◉Yes

Did you conduct 50% **or more** of your encounters in a county/area that does not have more than 50% **or more** of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period?) ◉No ○Yes

Measure#1: During the EHR reporting period, **more than** 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).

Complete the following information:

* **Numerator** = The number of patients (or patient authorized representative) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the EHR reporting period and the number of unique patients (or patient authorized representative) in the denominator who have accessed their health information through the use of an API during the EHR reporting period.

Please enter a numerator.

* **Denominator** = Number of unique patients seen by the EP during the EHR reporting period

Please enter a denominator.

Measure#2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Complete the following information:

* **Numerator** = The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the EHR reporting period.

Please enter a numerator.

* **Denominator** = The number of unique patients seen by the EP during the EHR reporting period.

Please enter a denominator.

Measure#3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for **more than** 5 percent of all unique patients seen by the EP during the EHR reporting period.

Complete the following information:

* **Numerator** = The number of patients in the denominator for whom data from non-clinical settings, which may include patient-generated health data, is captured through the CEHRT into the patient record during the EHR reporting period.

Please enter a numerator.

* **Denominator** = The number of unique patients seen by the EP during the EHR reporting period.

Please enter a denominator.

Attach Files

The following attachments are optional:

- Other

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

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Health Information Exchange

Health Information Exchange

* Red asterisk indicates a required field.

Objective: The EP provides a summary of care or record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria : Meeting the following criteria qualifies for the exclusion for the relevant measures.

Did you transfer a patient to another setting or refer a patient to another provider **less than** 100 times during the EHR reporting period? **(Measure #1)** — No ○ Yes ○

Did you conduct 50% **or more** of your encounters in a county/area that does not have **more than** 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? **(Measure #1)** — No ○ Yes ○

Were transitions or referrals received and patient encounters in which the provider has never before encountered the patient **fewer than** 100 during the EHR reporting period? **(Measure #2)** — No ○ Yes ○

Did you conduct 50% or more of your encounters in a county/area that does not have **more than** 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? **(Measure #2)** — No ○ Yes ○

Were transitions or referrals received and patient encounters in which the provider has never before encountered the patient **fewer than** 100 during the EHR reporting period? **(Measure #3)** — No ○ Yes ○

What if I still want to report on the measure?

Measure #1: For **more than** 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

Measure #2: For **more than** 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.

Measure #3: For **more than** 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies.(3) Current Problem list. Review of the patient's current and active diagnoses.

Attach Files

The following attachment is required:

- HIE Participation Agreement, or proof the EP met this measure, or written proof the exclusion applies to the EP

The following attachments are optional:

- Other

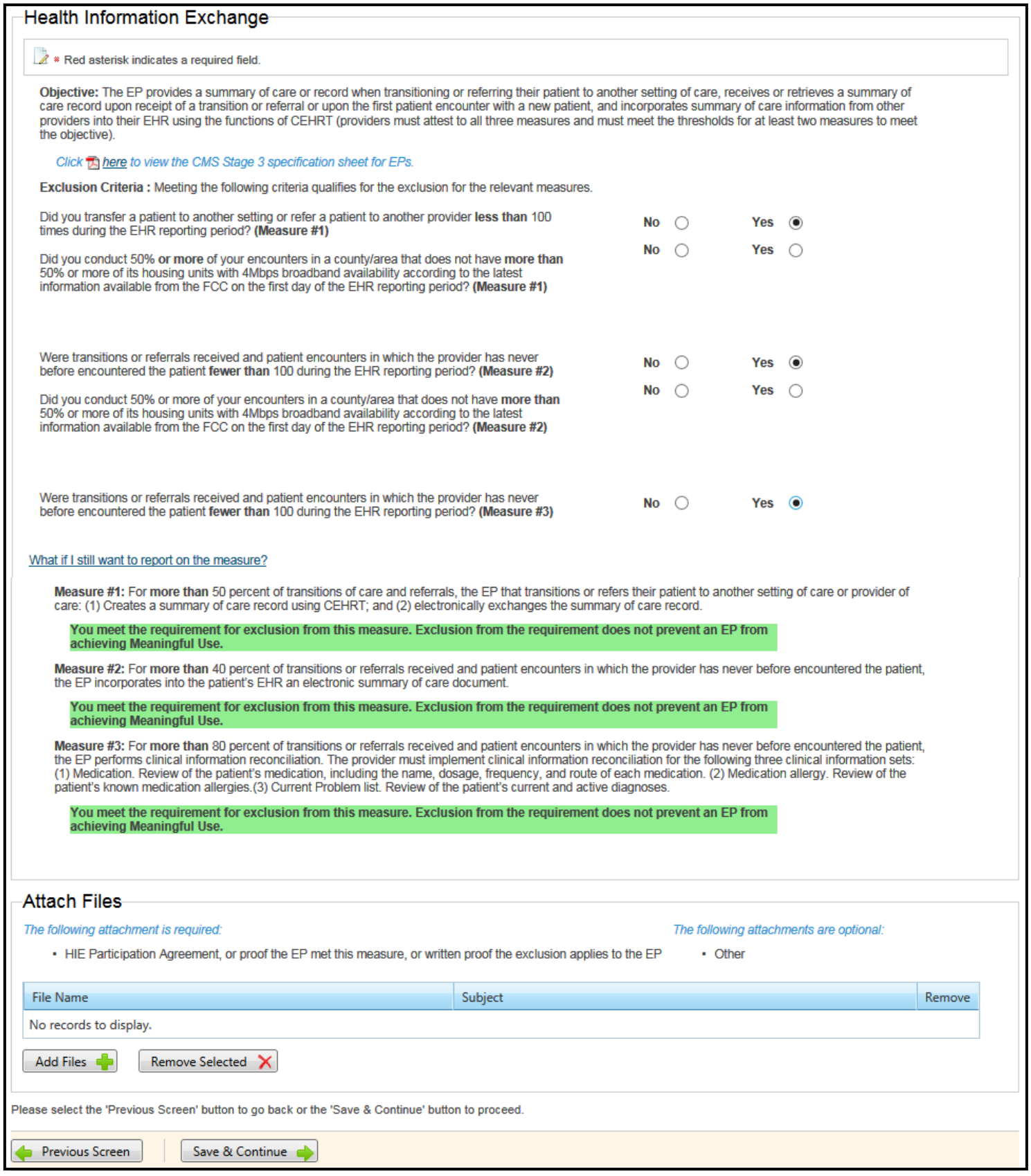
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Exclusions


Health Information Exchange
* Red asterisk indicates a required field.
Objective: The EP provides a summary of care or record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).
Click here to view the CMS Stage 3 specification sheet for EPs.
Exclusion Criteria : Meeting the following criteria qualifies for the exclusion for the relevant measures.
Did you transfer a patient to another setting or refer a patient to another provider less than 100 times during the EHR reporting period? (Measure #1)
No
Yes
Did you conduct 50% or more of your encounters in a county/area that does not have more than 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? (Measure #1)
No
Yes
Were transitions or referrals received and patient encounters in which the provider has never before encountered the patient fewer than 100 during the EHR reporting period? (Measure #2)
No
Yes
Did you conduct 50% or more of your encounters in a county/area that does not have more than 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? (Measure #2)
No
Yes
Were transitions or referrals received and patient encounters in which the provider has never before encountered the patient fewer than 100 during the EHR reporting period? (Measure #3)
No
Yes
What if I still want to report on the measure?
Measure #1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Measure #2: For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Measure #3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies.(3) Current Problem list. Review of the patient's current and active diagnoses.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Attach Files
The following attachment is required:
HIE Participation Agreement, or proof the EP met this measure, or written proof the exclusion applies to the EP
The following attachments are optional:
Other
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Previous Screen
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Health Information Exchange

* Red asterisk indicates a required field.

Objective: The EP provides a summary of care or record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria : Meeting the following criteria qualifies for the exclusion for the relevant measures.

Did you transfer a patient to another setting or refer a patient to another provider **less than** 100 times during the EHR reporting period? **(Measure #1)** — **No** (●) **Yes** ( )

Did you conduct 50% **or more** of your encounters in a county/area that does not have **more than** 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? **(Measure #1)** — **No** ( ) **Yes** ( )

Were transitions or referrals received and patient encounters in which the provider has never before encountered the patient **fewer than** 100 during the EHR reporting period? **(Measure #2)** — **No** (●) **Yes** ( )

Did you conduct 50% or more of your encounters in a county/area that does not have **more than** 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? **(Measure #2)** — **No** ( ) **Yes** ( )

Were transitions or referrals received and patient encounters in which the provider has never before encountered the patient **fewer than** 100 during the EHR reporting period? **(Measure #3)** — **No** (●) **Yes** ( )

What if I still want to report on the measure?

Measure #1: For **more than** 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

Complete the following information:

* [ ] **Numerator** = The number of transitions of care and referrals in the denominator where a summary of care record was created using Certified EHR technology and is exchanged electronically.
Please enter a numerator.

* [ ] **Denominator** = Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
Please enter a denominator.

Measure #2: For **more than** 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology:

( ) This data was extracted from ALL patient records not just those maintained using certified EHR technology.

( ) This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

* [ ] **Numerator** = Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the certified EHR technology.
Please enter a numerator.

* [ ] **Denominator** = Number of patient encounters during the EHR reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.
Please enter a denominator.

Measure #3: For **more than** 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies.(3) Current Problem list. Review of the patient's current and active diagnoses.

Complete the following information:

* [ ] **Numerator** = The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: Medication list, medication allergy list, and current problem list.
Please enter a numerator.

* [ ] **Denominator** = Number of transitions of care or referrals during the EHR reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient
Please enter a denominator.

Attach Files

The following attachment is required:

- HIE Participation Agreement, or proof the EP met this measure, or written proof the exclusion applies to the EP

The following attachments are optional:

- Other

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

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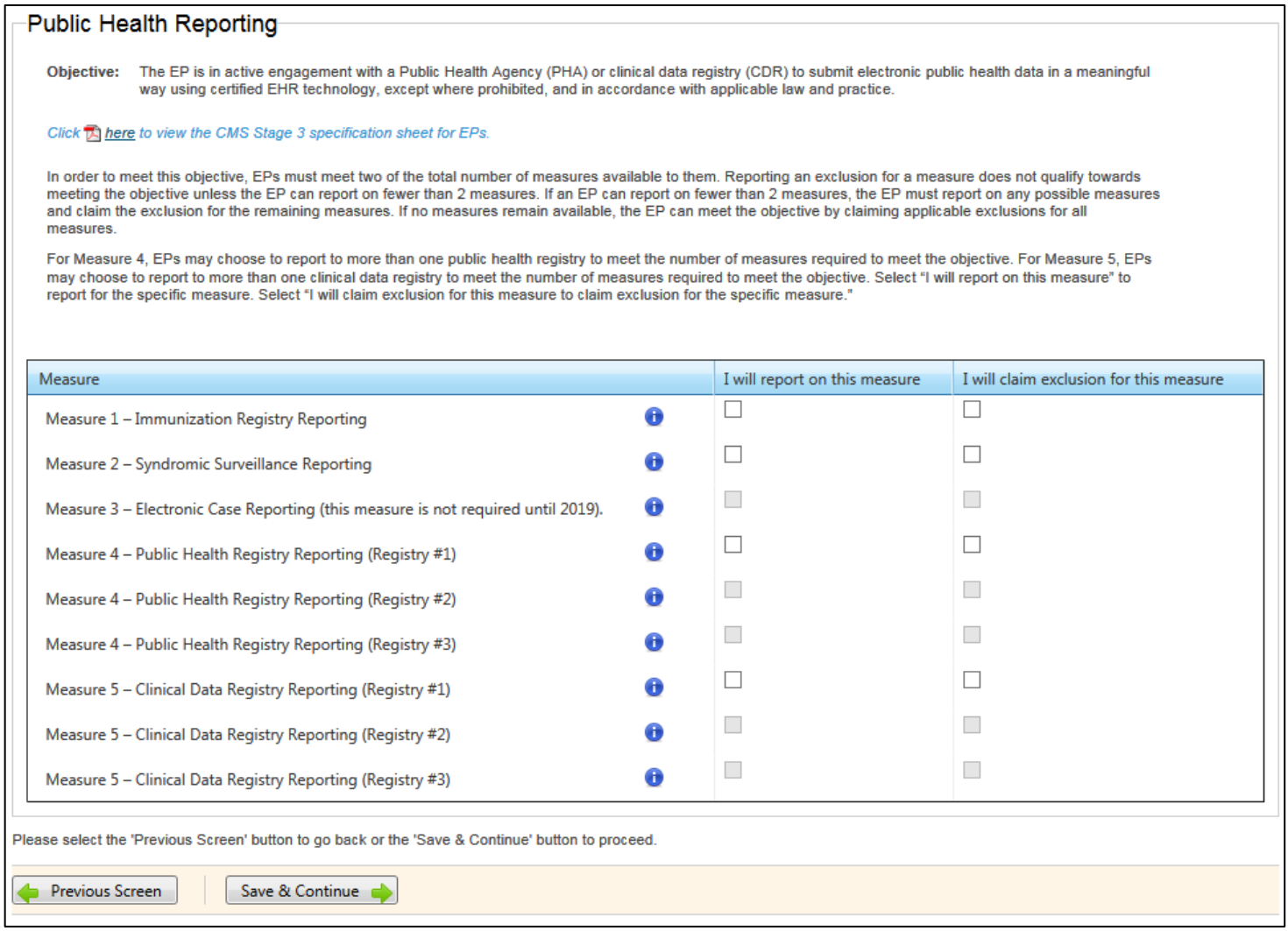
Public Health Reporting



Public Health Reporting

Objective: The EP is in active engagement with a Public Health Agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Click here to view the CMS Stage 3 specification sheet for EPs.

In order to meet this objective, EPs must meet two of the total number of measures available to them. Reporting an exclusion for a measure does not qualify towards meeting the objective unless the EP can report on fewer than 2 measures. If an EP can report on fewer than 2 measures, the EP must report on any possible measures and claim the exclusion for the remaining measures. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all measures.

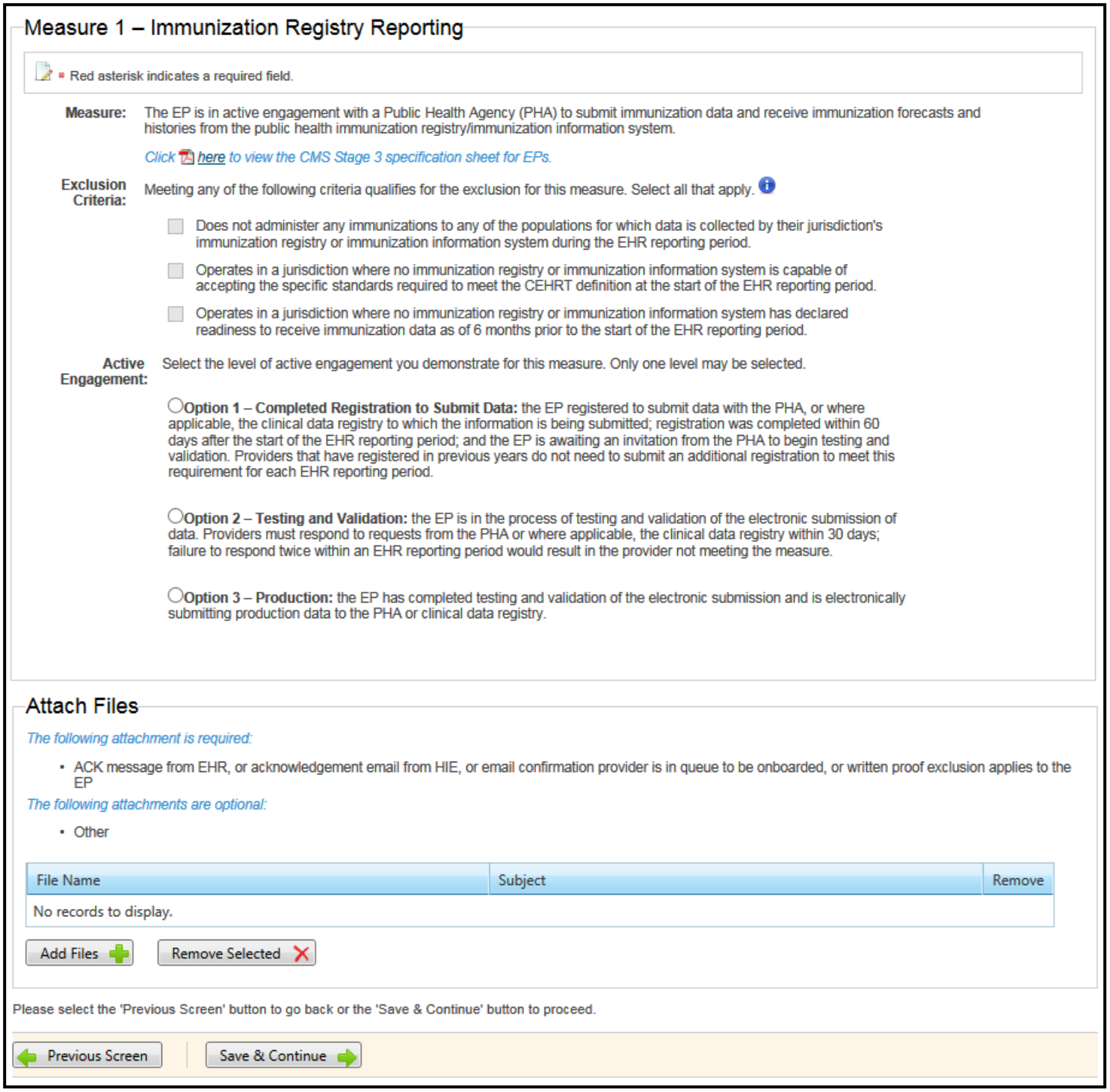
For Measure 4, EPs may choose to report to more than one public health registry to meet the number of measures required to meet the objective. For Measure 5, EPs may choose to report to more than one clinical data registry to meet the number of measures required to meet the objective. Select "I will report on this measure" to report for the specific measure. Select "I will claim exclusion for this measure to claim exclusion for the specific measure."

Measure	I will report on this measure	I will claim exclusion for this measure
Measure 1 – Immunization Registry Reporting	☐	☐
Measure 2 – Syndromic Surveillance Reporting	☐	☐
Measure 3 – Electronic Case Reporting (this measure is not required until 2019).	☐	☐
Measure 4 – Public Health Registry Reporting (Registry #1)	☐	☐
Measure 4 – Public Health Registry Reporting (Registry #2)	☐	☐
Measure 4 – Public Health Registry Reporting (Registry #3)	☐	☐
Measure 5 – Clinical Data Registry Reporting (Registry #1)	☐	☐
Measure 5 – Clinical Data Registry Reporting (Registry #2)	☐	☐
Measure 5 – Clinical Data Registry Reporting (Registry #3)	☐	☐

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Immunization Registry Reporting



Measure 1 – Immunization Registry Reporting

* Red asterisk indicates a required field.

Measure: The EP is in active engagement with a Public Health Agency (PHA) to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system.

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.

- ☐ Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.
- ☐ Operates in a jurisdiction where no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
- ☐ Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the EHR reporting period.

Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

- ○ **Option 1 – Completed Registration to Submit Data:** the EP registered to submit data with the PHA, or where applicable, the clinical data registry to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
- ○ **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.
- ○ **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or clinical data registry.

Attach Files

The following attachment is required:

- ACK message from EHR, or acknowledgement email from HIE, or email confirmation provider is in queue to be onboarded, or written proof exclusion applies to the EP

The following attachments are optional:

- Other

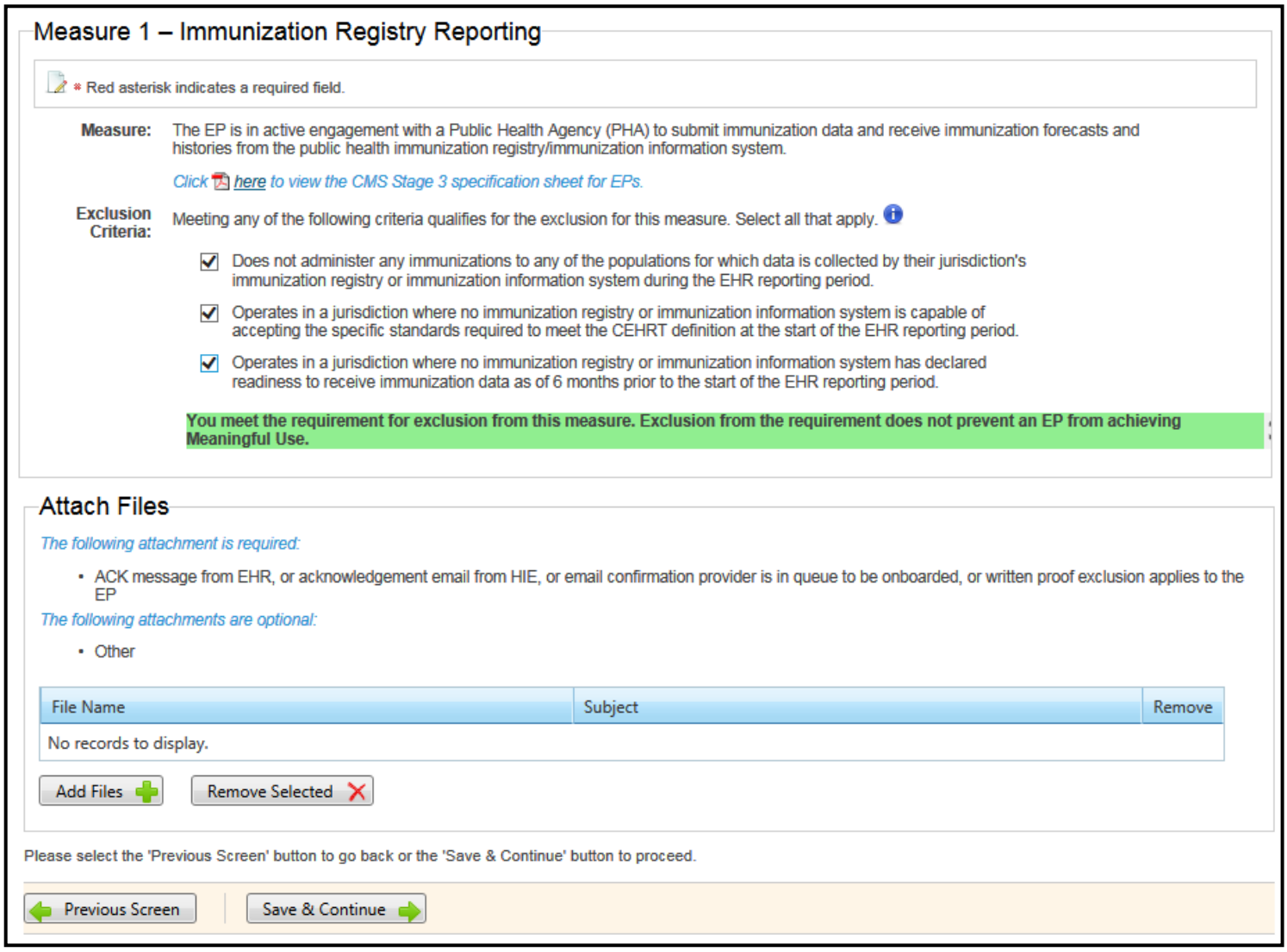
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Exclusions


Measure 1 – Immunization Registry Reporting
* Red asterisk indicates a required field.
Measure:
The EP is in active engagement with a Public Health Agency (PHA) to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system.
Click here to view the CMS Stage 3 specification sheet for EPs.
Exclusion Criteria:
Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.
Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.
Operates in a jurisdiction where no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the EHR reporting period.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Attach Files
The following attachment is required:
ACK message from EHR, or acknowledgement email from HIE, or email confirmation provider is in queue to be onboarded, or written proof exclusion applies to the EP
The following attachments are optional:
Other
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
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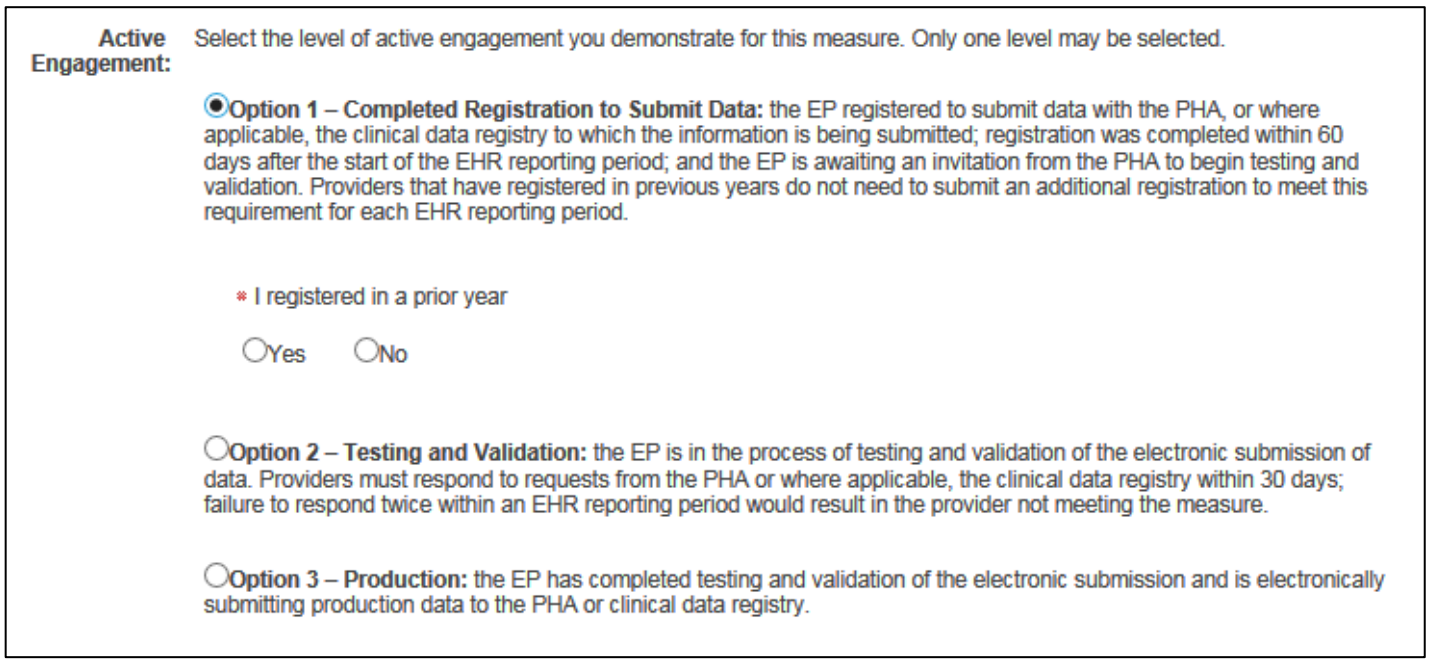
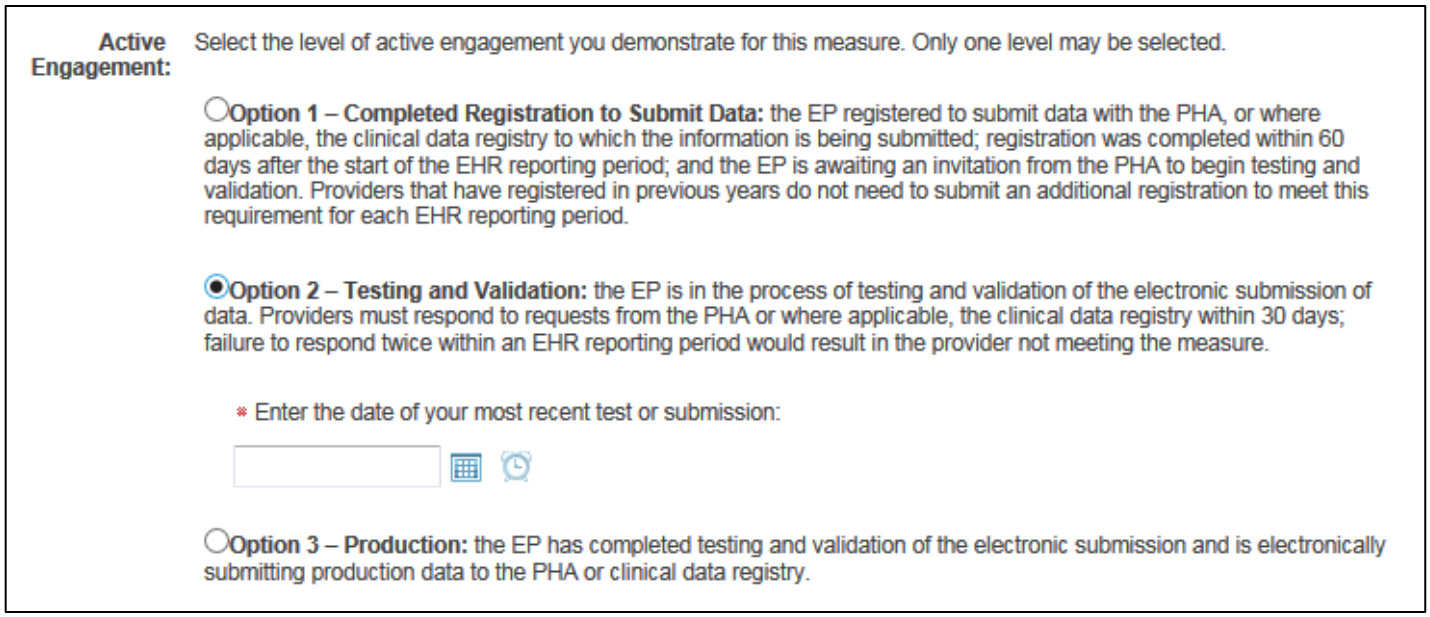
Active Engagement Option 1- Completed Registration to Submit Data



Active Engagement Option 2- Testing and Validation



Active Engagement Option 3- Production

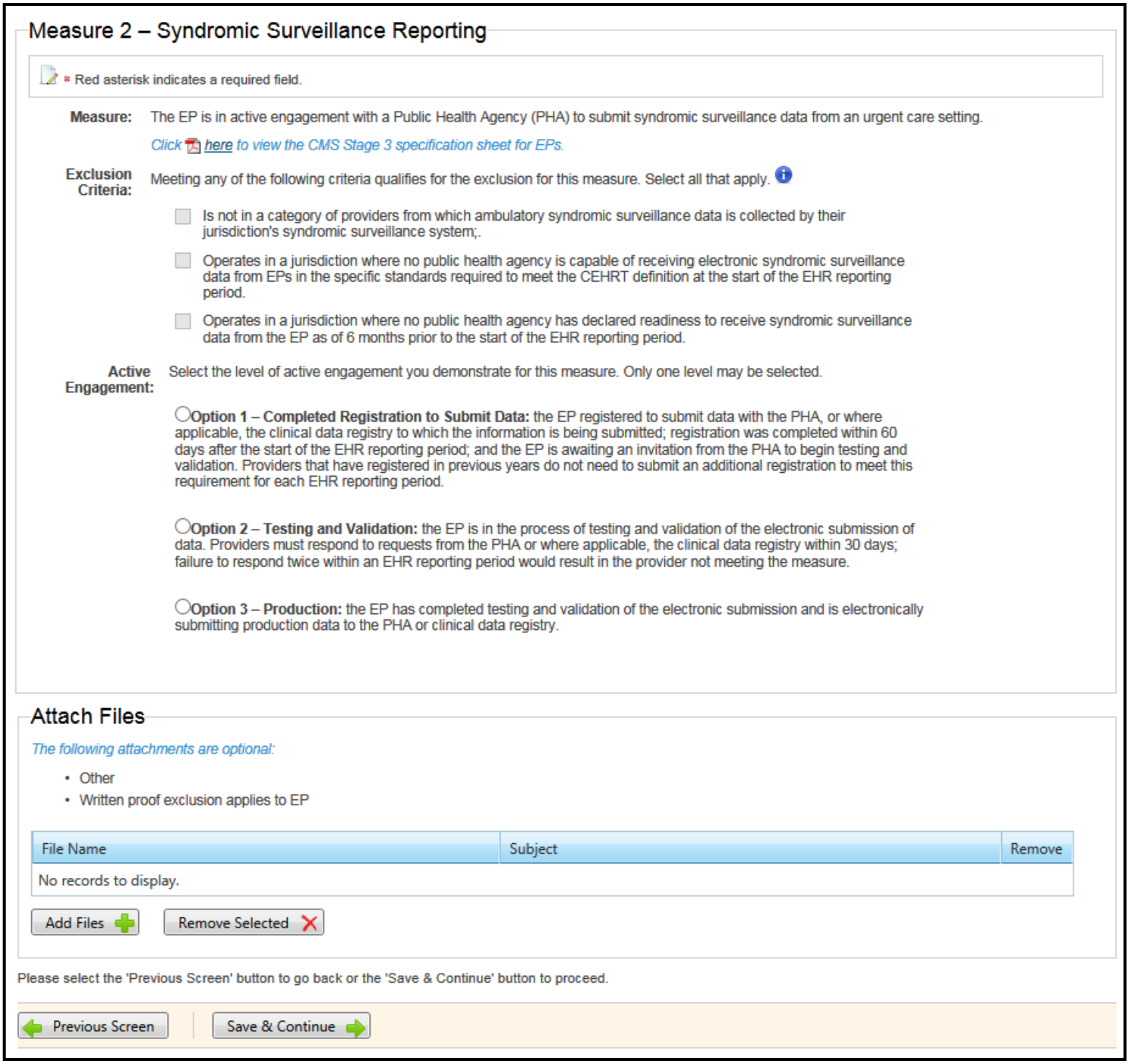
Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

○ **Option 1 – Completed Registration to Submit Data:** the EP registered to submit data with the PHA, or where applicable, the clinical data registry to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

○ **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.

◉ **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or clinical data registry.

Syndromic Surveillance



Measure 2 – Syndromic Surveillance Reporting

* Red asterisk indicates a required field.

Measure: The EP is in active engagement with a Public Health Agency (PHA) to submit syndromic surveillance data from an urgent care setting.

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.

- Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;.
- Operates in a jurisdiction where no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
- Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from the EP as of 6 months prior to the start of the EHR reporting period.

Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

- **Option 1 – Completed Registration to Submit Data:** the EP registered to submit data with the PHA, or where applicable, the clinical data registry to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
- **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.
- **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or clinical data registry.

Attach Files

The following attachments are optional:

- Other
- Written proof exclusion applies to EP

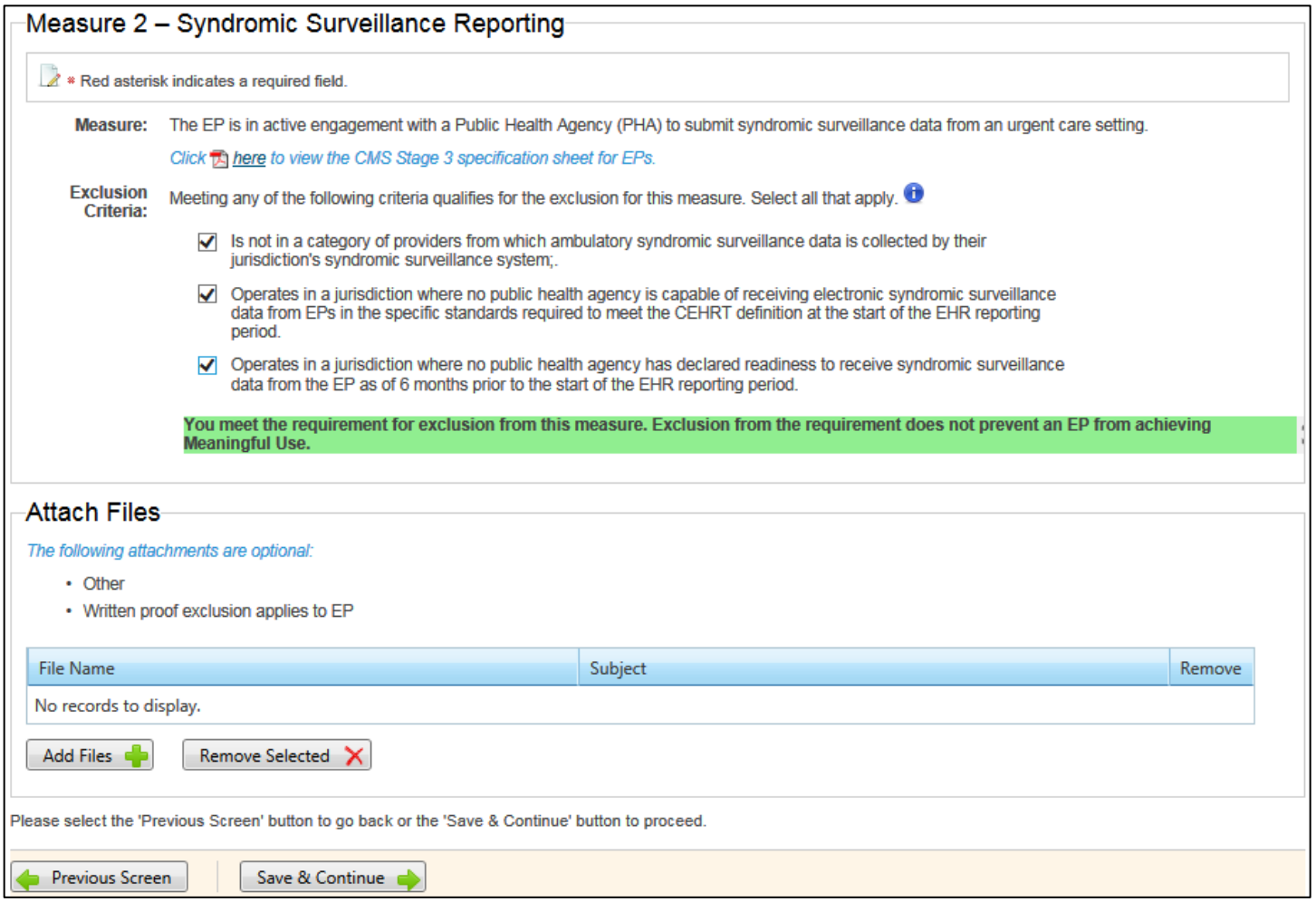
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

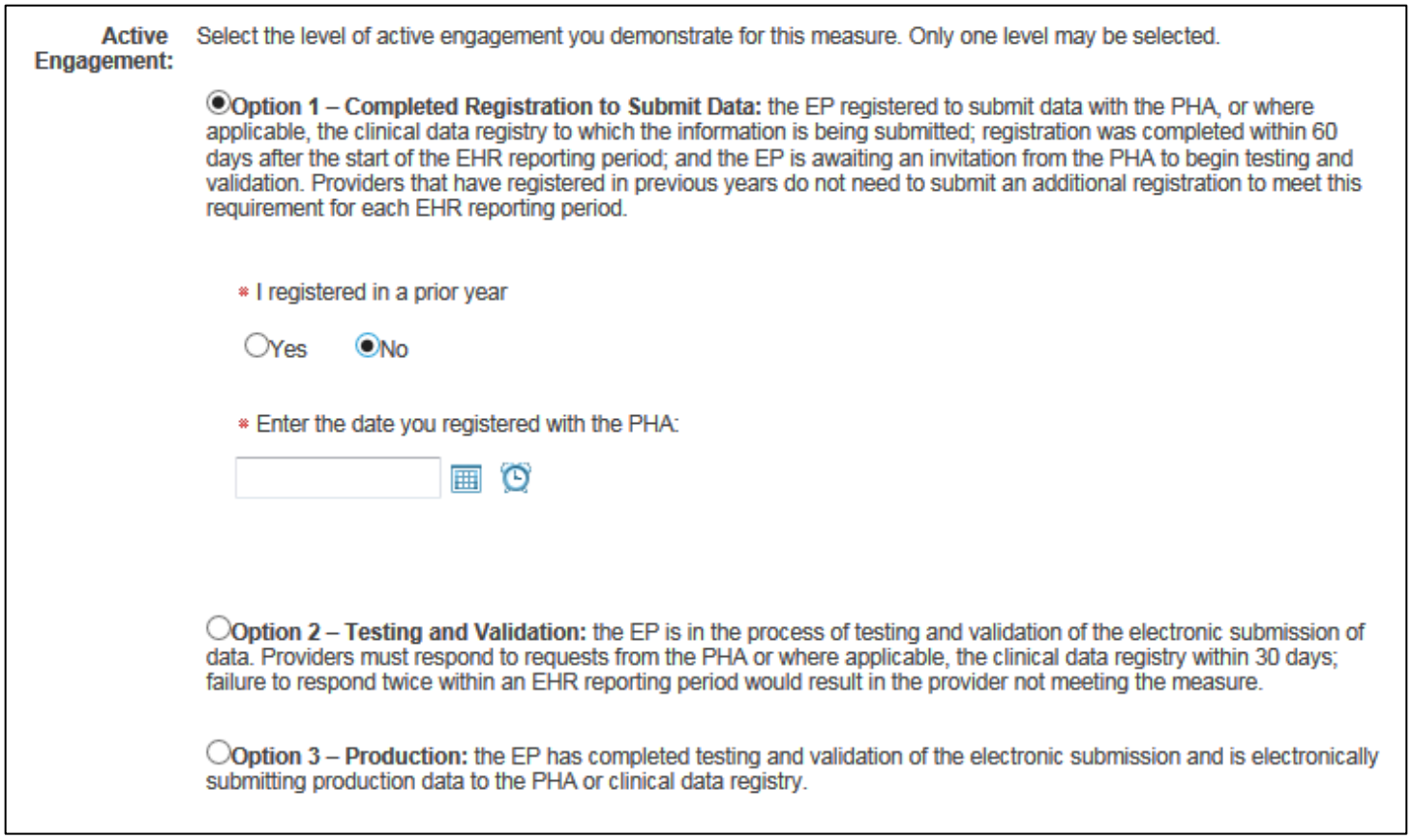
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

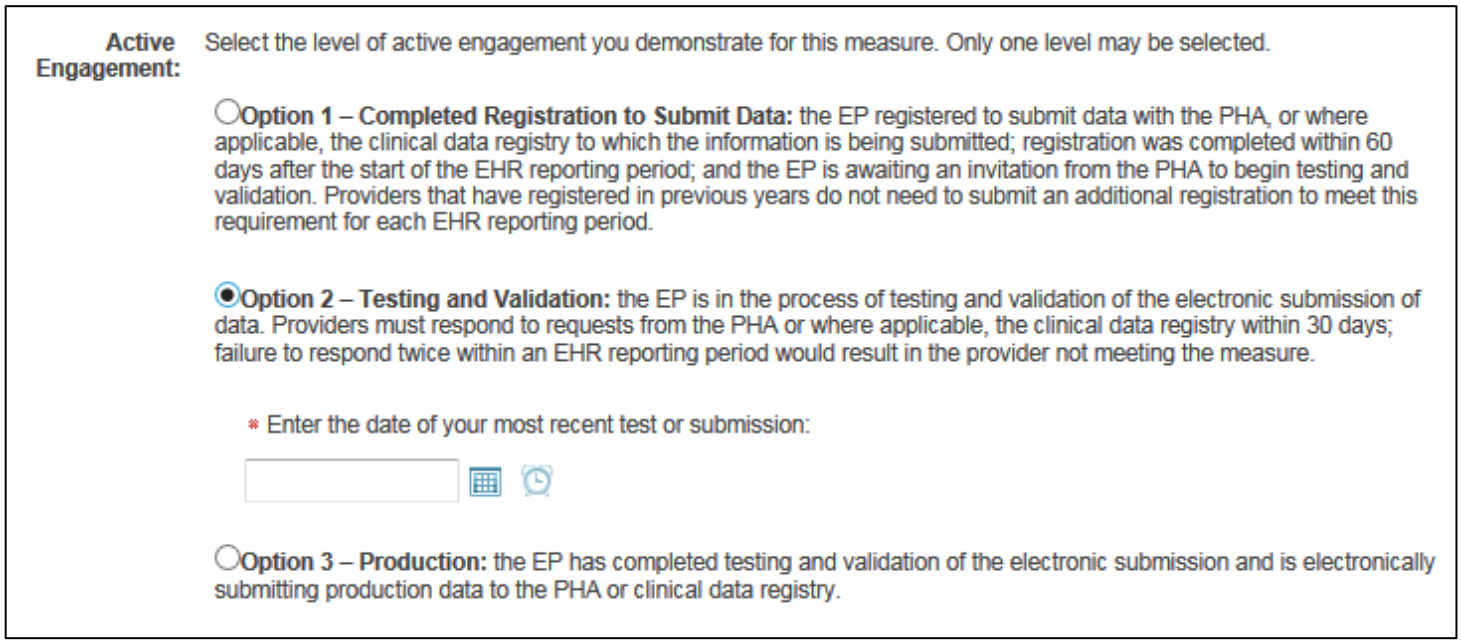
Exclusions



Active Engagement Option 1- Completed Registration to Submit Data



Active Engagement Option 2- Testing and Validation



Active Engagement Option 3- Production

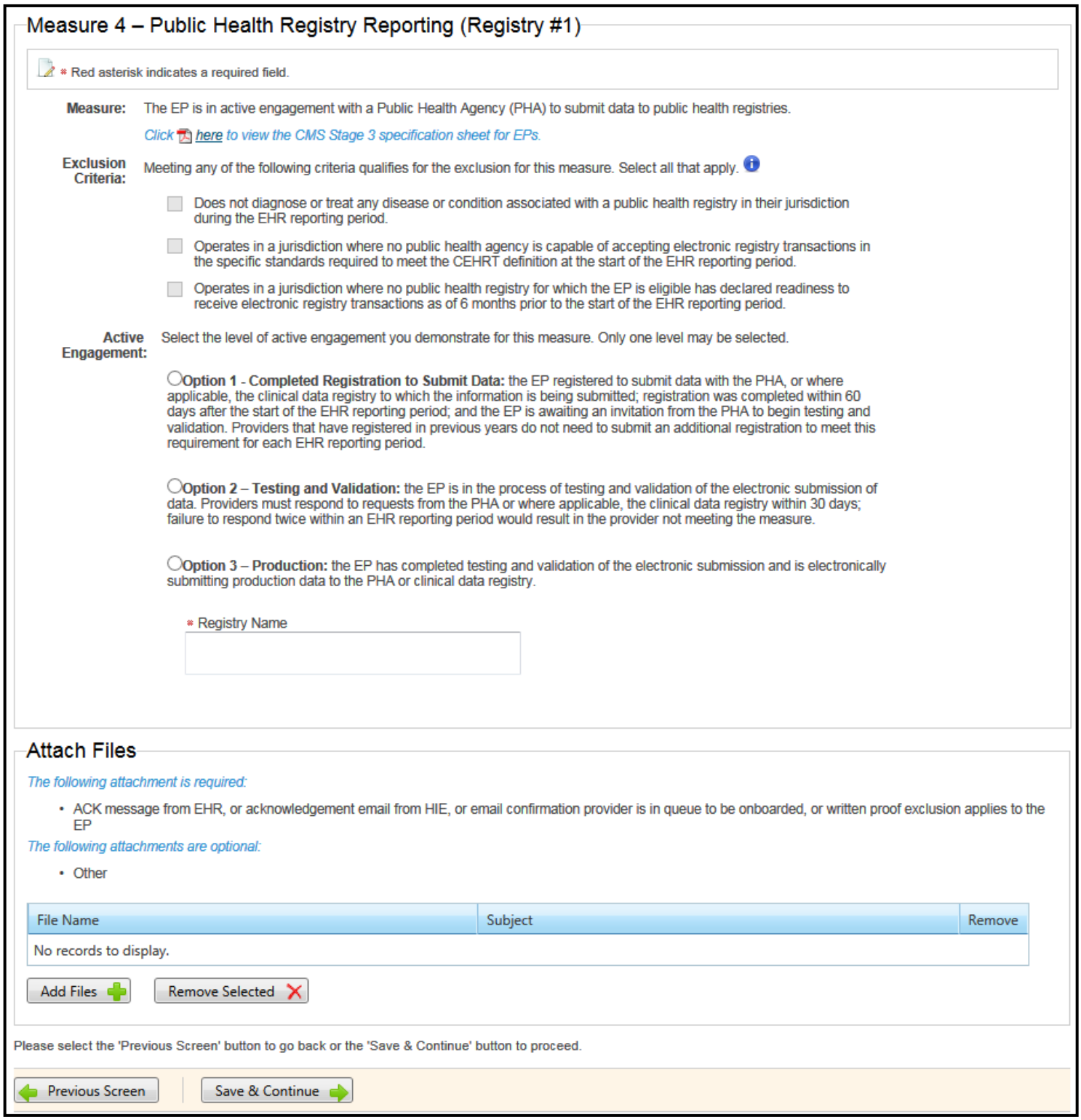
Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

○ **Option 1 – Completed Registration to Submit Data:** the EP registered to submit data with the PHA, or where applicable, the clinical data registry to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

○ **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.

◉ **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or clinical data registry.

Public Health Registry Reporting (Registry #1, #2, #3)



Measure 4 – Public Health Registry Reporting (Registry #1)

* Red asterisk indicates a required field.

Measure: The EP is in active engagement with a Public Health Agency (PHA) to submit data to public health registries.

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.

- Does not diagnose or treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period.
- Operates in a jurisdiction where no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
- Operates in a jurisdiction where no public health registry for which the EP is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.

Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

- **Option 1 - Completed Registration to Submit Data:** the EP registered to submit data with the PHA, or where applicable, the clinical data registry to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
- **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.
- **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or clinical data registry.

* Registry Name

Attach Files

The following attachment is required:

- ACK message from EHR, or acknowledgement email from HIE, or email confirmation provider is in queue to be onboarded, or written proof exclusion applies to the EP

The following attachments are optional:

- Other

File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

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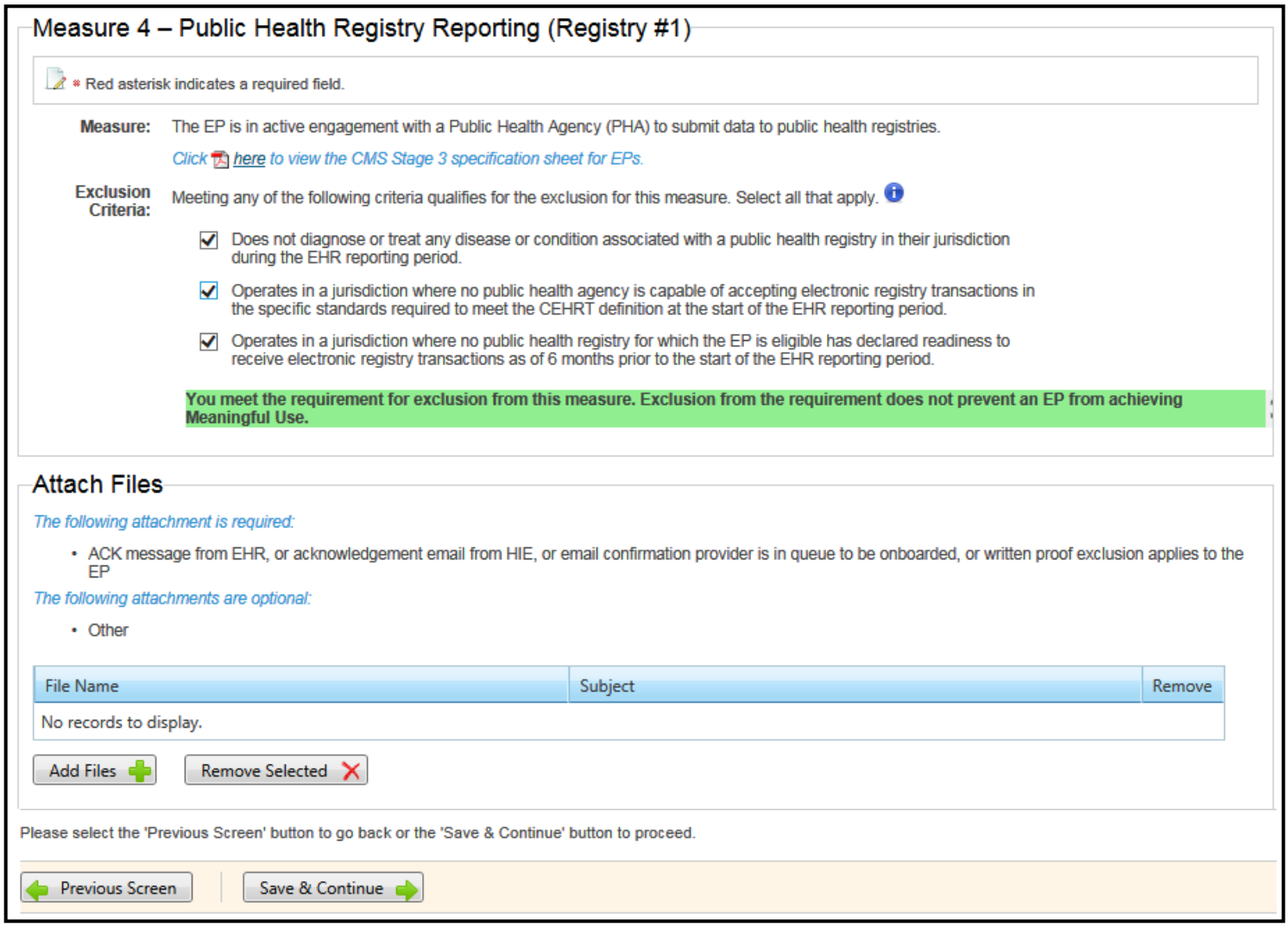
Exclusions


Measure 4 – Public Health Registry Reporting (Registry #1)
* Red asterisk indicates a required field.
Measure:
The EP is in active engagement with a Public Health Agency (PHA) to submit data to public health registries.
Click here to view the CMS Stage 3 specification sheet for EPs.
Exclusion Criteria:
Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.
Does not diagnose or treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period.
Operates in a jurisdiction where no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
Operates in a jurisdiction where no public health registry for which the EP is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.
You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.
Attach Files
The following attachment is required:
ACK message from EHR, or acknowledgement email from HIE, or email confirmation provider is in queue to be onboarded, or written proof exclusion applies to the EP
The following attachments are optional:
Other
File Name
Subject
Remove
No records to display.
Add Files
Remove Selected
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.
Previous Screen
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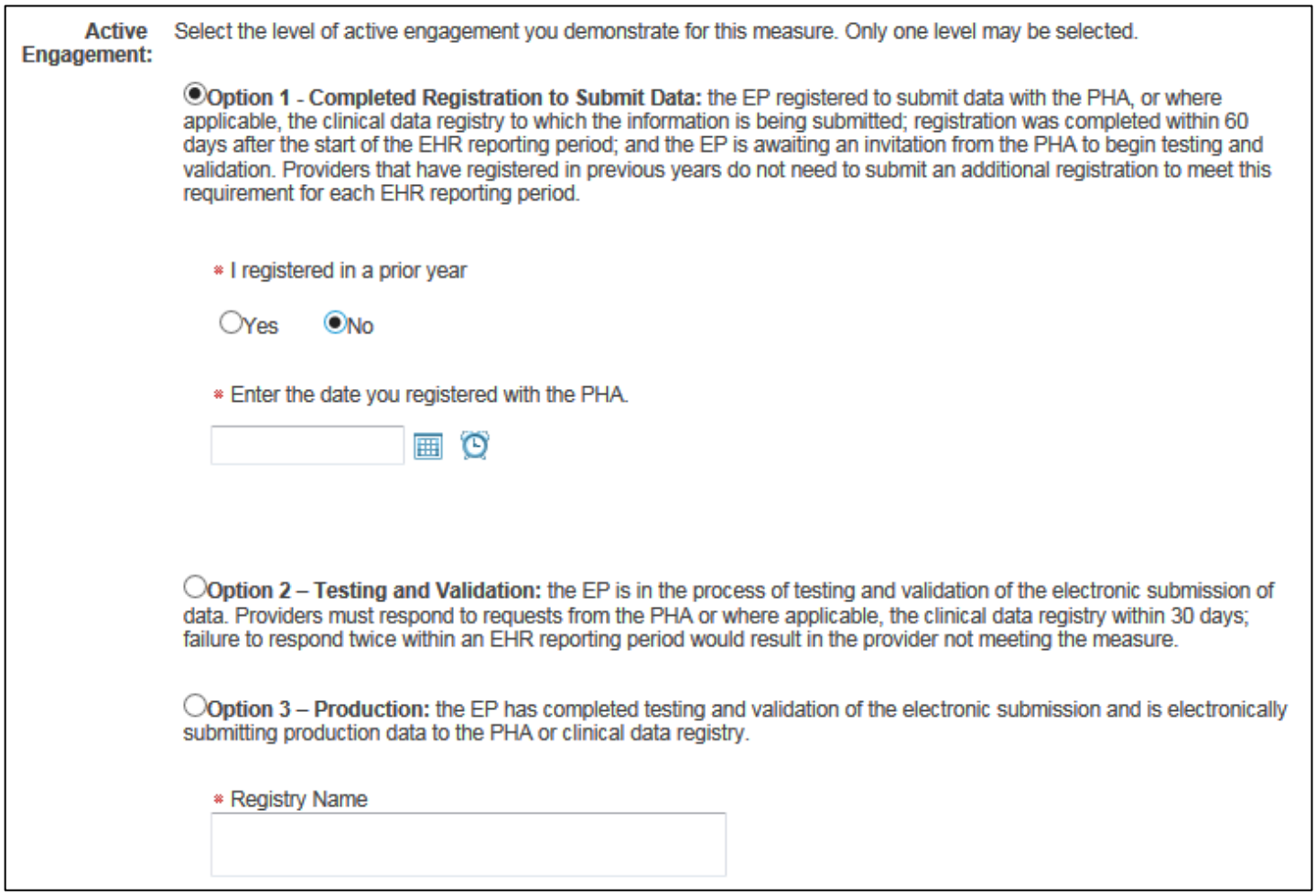
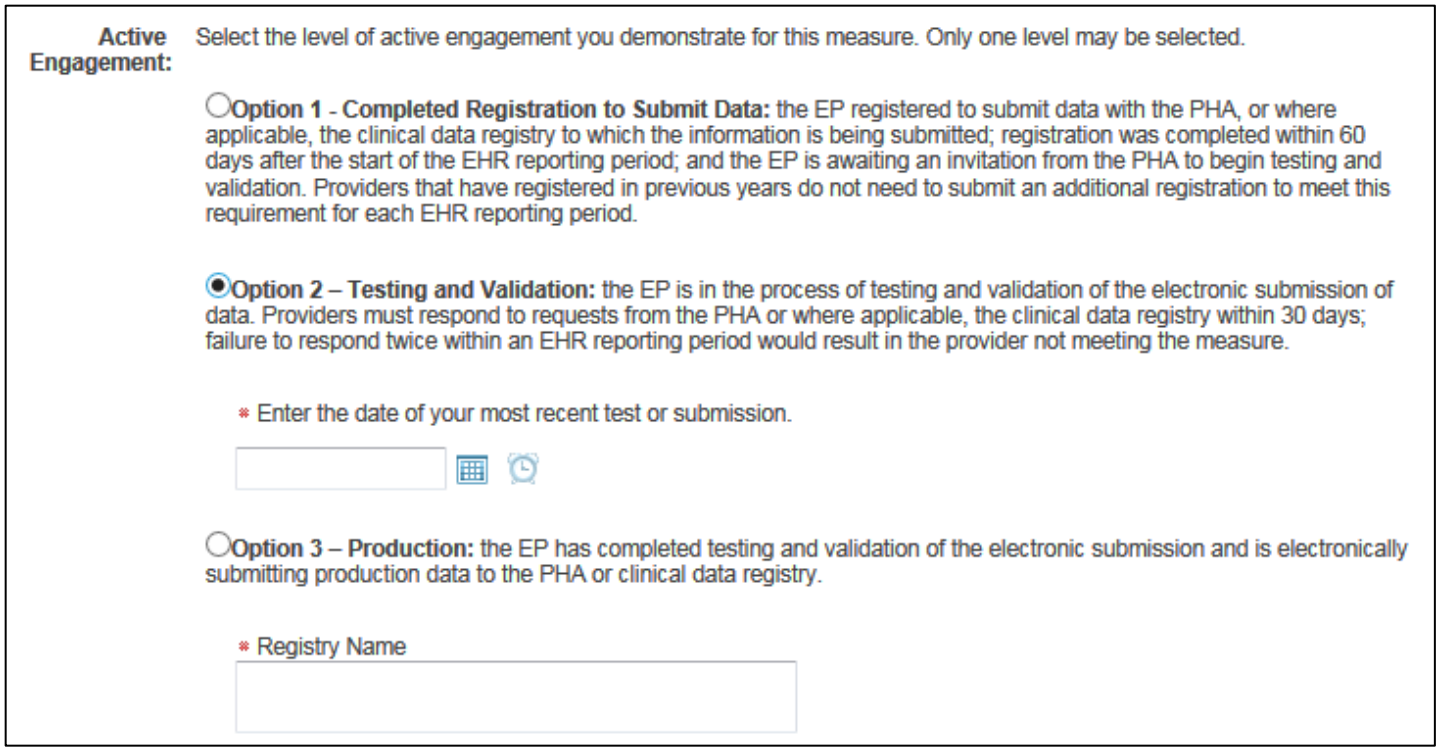
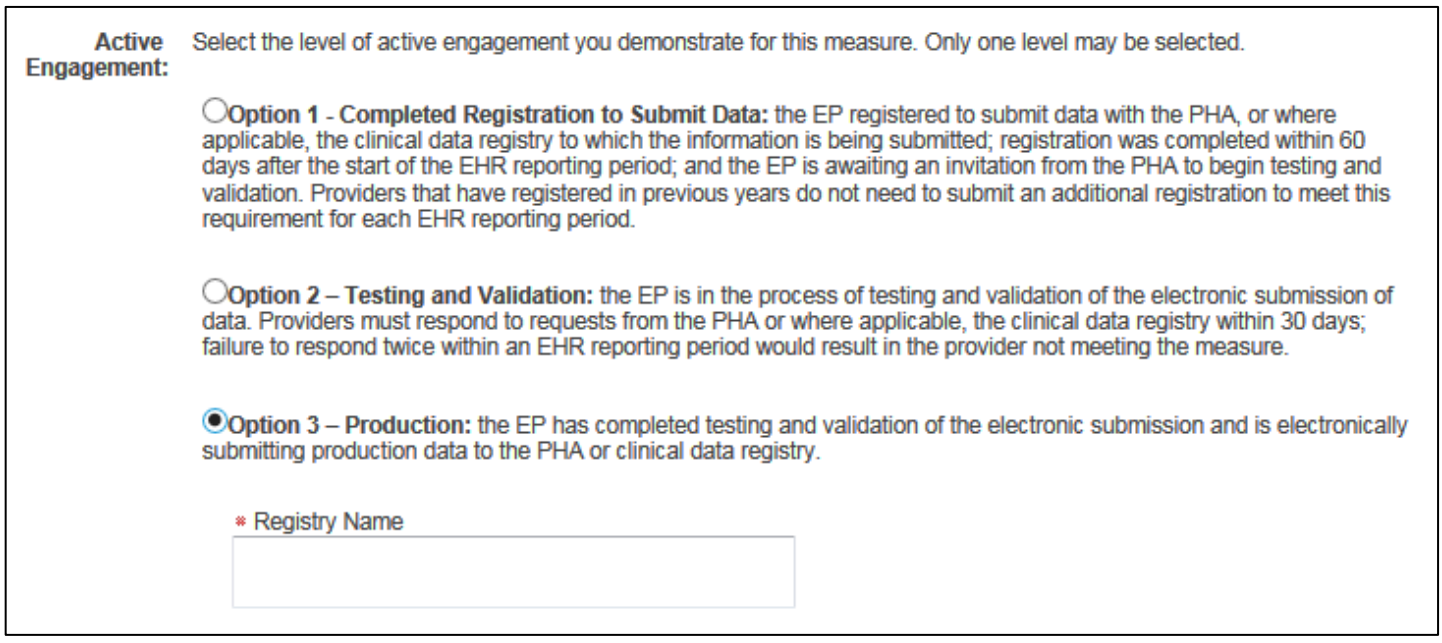
Active Engagement Option 1- Completed Registration to Submit Data



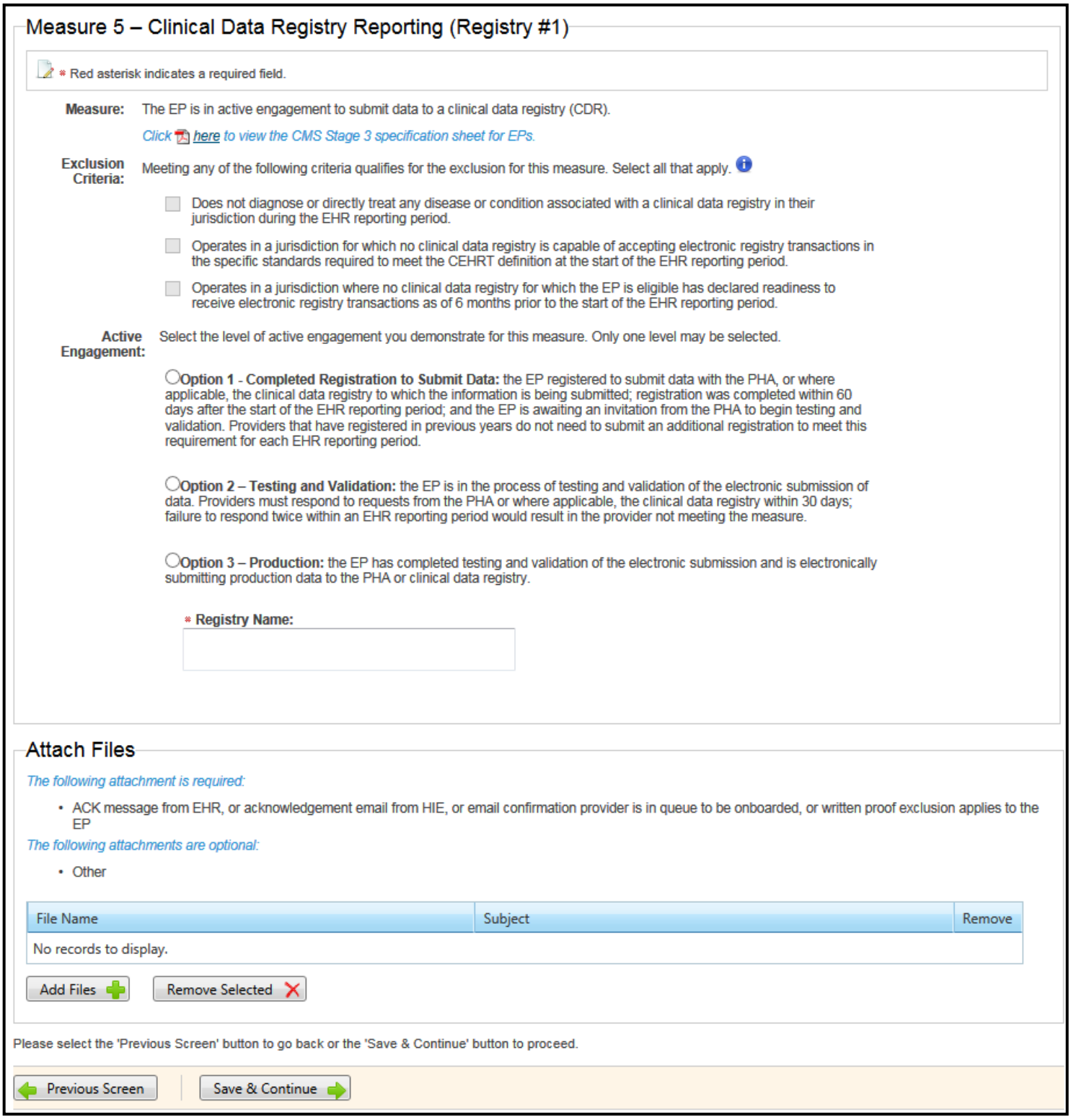
Active Engagement Option 2- Testing and Validation



Active Engagement Option 3- Production



Clinical Data Registry Reporting (Registry #1, #2, #3)



Measure 5 – Clinical Data Registry Reporting (Registry #1)

* Red asterisk indicates a required field.

Measure: The EP is in active engagement to submit data to a clinical data registry (CDR).

Click here to view the CMS Stage 3 specification sheet for EPs.

Exclusion Criteria: Meeting any of the following criteria qualifies for the exclusion for this measure. Select all that apply.

- ☐ Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period.
- ☐ Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.
- ☐ Operates in a jurisdiction where no clinical data registry for which the EP is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.

Active Engagement: Select the level of active engagement you demonstrate for this measure. Only one level may be selected.

- ○ **Option 1 - Completed Registration to Submit Data:** the EP registered to submit data with the PHA, or where applicable, the clinical data registry to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA to begin testing and validation. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.
- ○ **Option 2 – Testing and Validation:** the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in the provider not meeting the measure.
- ○ **Option 3 – Production:** the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or clinical data registry.

* **Registry Name:**

Attach Files

The following attachment is required:

- ACK message from EHR, or acknowledgement email from HIE, or email confirmation provider is in queue to be onboarded, or written proof exclusion applies to the EP

The following attachments are optional:

- Other

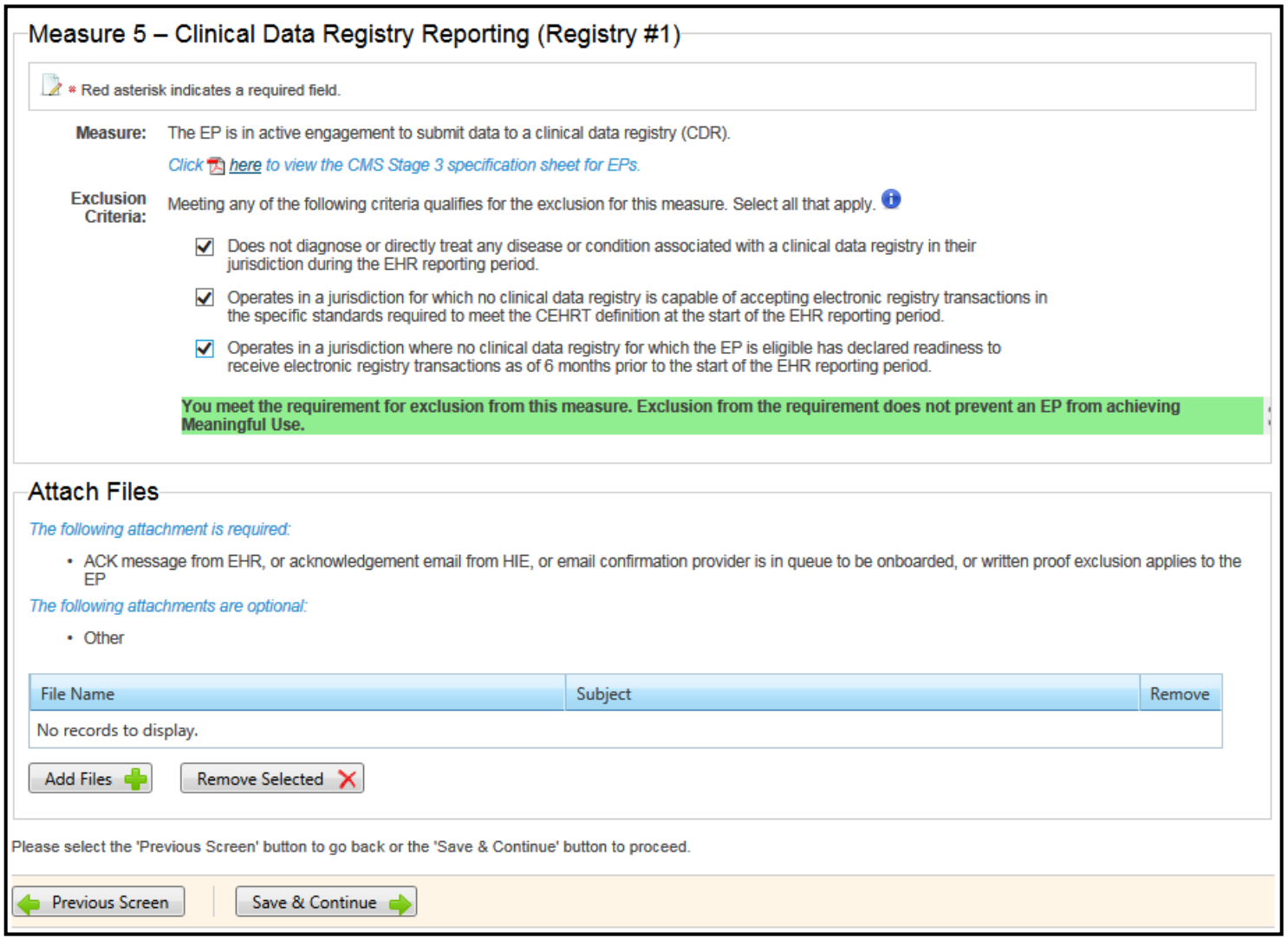
File Name	Subject	Remove
No records to display.		

Add Files | Remove Selected

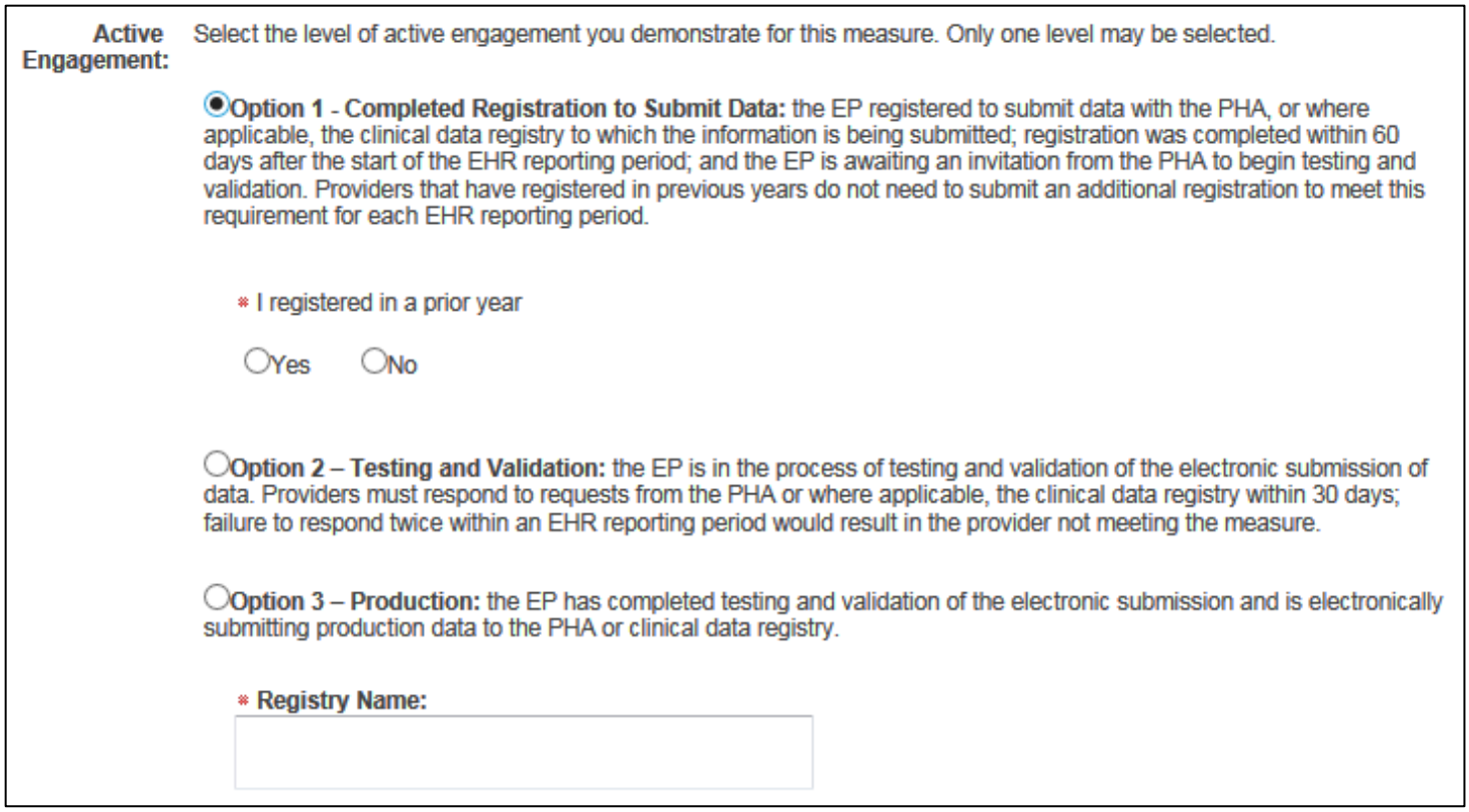
Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

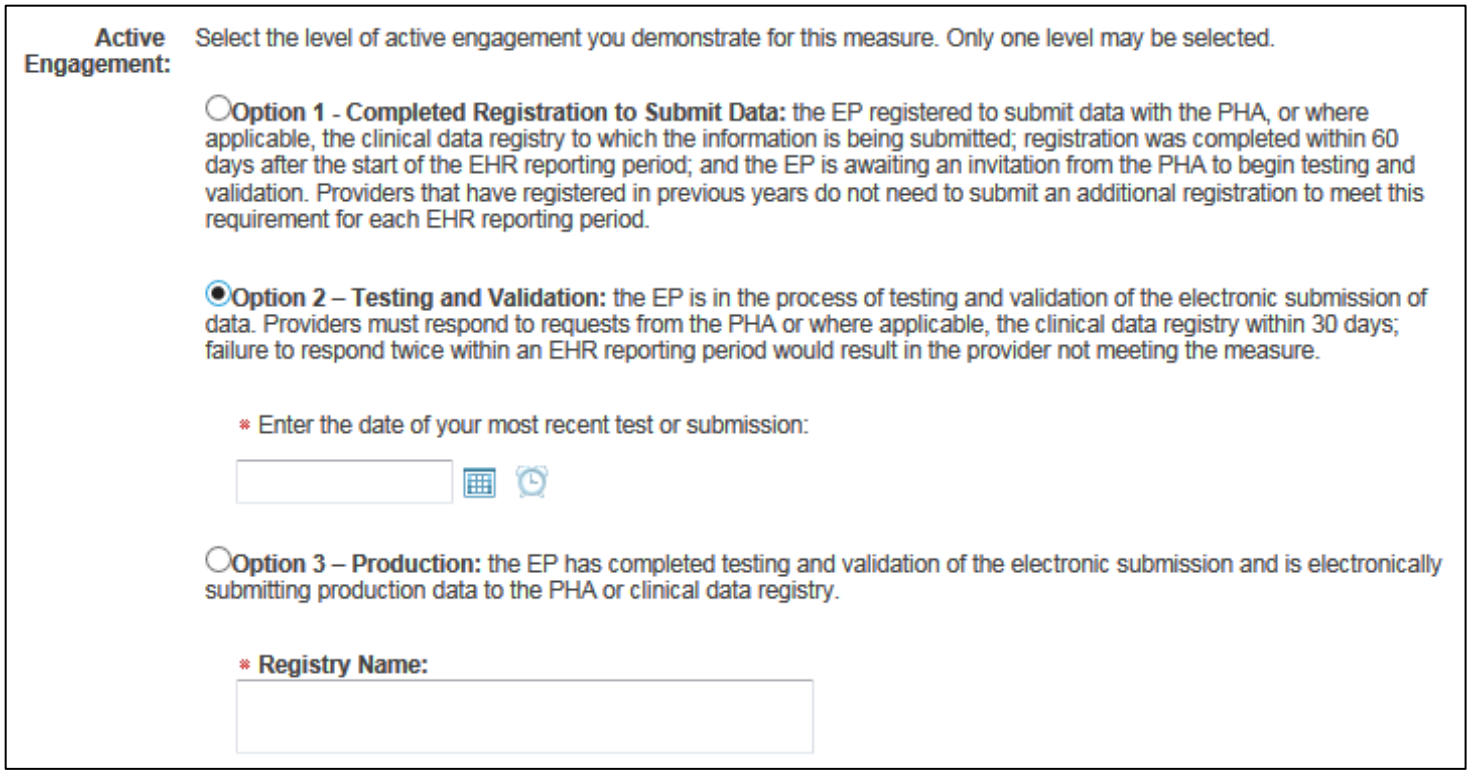
Exclusions



Active Engagement Option 1- Completed Registration to Submit Data



Active Engagement Option 2- Testing and Validation



Active Engagement Option 3- Production